National Summary of State Medicaid Managed Care Programs

Program Descriptions as of June 30, 1995

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1995

U.S. Department of Health and Human Services
Health Care Financing Administration
Office of Managed Care

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The National Summary of State Medicaid Managed Care Programs is assembled annually by the Office of Managed Care of the Health Care Financing Administration (HCFA), Department of Health and Human Services. The descriptions of the States' managed care waivers as of June 30, 1995 were submitted either by representatives in HCFA Regional Offices or by the corresponding States and collected by the Medicaid Managed Care Team. The National Summary serves as a reference and informational guide to the public as well as other governmental agencies.

Previous publications of the document included a single narrative entry from each State describing all of the managed care projects in the State. This year's publication includes uniform data for each 1915(b) and 1115(a) waiver program. Voluntary programs are not included this year, but they will be in the 1996 National Summary.

The Office of Managed Care wishes to extend special thanks to Anna Meyers, Carolyn Lawson, and Tammi Hessen of the Medicaid Managed Care Team for their assistance in developing this report. If there are any questions regarding the content of this document, please contact the Medicaid Managed Care Team at (410) 786-0704.

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Health Care Financing Administration
Office of Managed Care

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Section 1915(b)

Freedom of Choice Waivers

Alabama

Maternity Waiver Program

PROGRAM NAME: Maternity Waiver Program	*ORIGINAL IMPLEMENTATION DATE:* September 1988
CONTACT : Debra Moore (334) *242-5015*	*EXPIRATION DATE:* September 30, 1995 We will be asking for an extension.
GEOGRAPHIC AREAS: Currently in 43 counties	*NUMBER OF ENROLLEES:* about 23,000

FFS (PCCM) OR PRE-PAID OR BOTH: PCCM type payment is made through an expanded global fee.

STATUTES UTILIZED: 1902(a)(1), 1902(a)(10), 1902(a)(23), 1915(b)(1), 1915(b)(3), 1915(b)(4), 1902(a)(B)

STATUTES WAIVED: 1902(a)(1), 1902(a)(10), 1902(a)(23), 1915(b)(1)

POPULATION CATEGORIES INCLUDED: Pregnant women of any eligibility coverage group, i.e., SOBRA, AFDC, etc., age 10-55.

POPULATION CATEGORIES EXCLUDED: None.

SERVICES INCLUDED: Antepartum care, Hospitalization, Delivery, Anesthesiology, Postpartum care, Care Coordination.

PCP PROVIDER TYPES: N/A.

FUTURE PLANS: We hope to renew our plan to extend it for another two years.

Alabama Maternity Waiver Program

The Maternity Waiver Program has been in operation since September 1988. The waiver as of today has 43 counties which are covered through one of 25 Primary Providers. One of the major issues regarding the waiver is getting prenatal care to the recipients in a timely manner.

Recipients serviced by the waiver are the recipients that are eligible through one of these aid categories: (1) SOBRA adults, (2) SSI-disabled, (3) AFDC.

The program operates by directing women to certain care givers and by augmenting their medical care with care coordination. Care coordinations work with the women to set up a plan of care, make appropriate referrals, provide education, follow-up on missed appointments, and assist with transportation.

Directing the patient to a specific provider enables Medicaid to set up a primary provider network. Assess to care through one provider eliminates fragmented and insufficient care while assuring that recipients receive adequate care.

Arkansas

Primary Care Physician

PROGRAM NAME: Primary Care Physician *ORIGINAL IMPLEMENTATION :* February 1, 1994

CONTACT: Roy Jeffus, (501) 682-1638 EXPIRATION *DATE:* January 31, 1996

GEOGRAPHIC AREAS: Statewide *NUMBER OF ENROLLEES:* 137,070

FFS (PCCM) PREPAID OR BOTH: PCCM

STATUTES UTILIZED: 1915(b)(1)

STATUTES WAIVED: 1902(a)(10)(B), 1902(a)(23)

POPULATION CATEGORIES INCLUDED: All Title XIX eligibles

POPULATION CATEGORIES EXCLUDED: Recipients who are Children's Medical Services (CMS) recipients. Recipients who are outside the State of Arkansas (The State is defined as inside the borders of the State of Arkansas, in a trade area city or in a bordering state city which is not a trade area city.) will not be required to have a primary care physician during their absence from the state. Recipients who have Medicare or other insurance. Recipients residing in N/H or ICF/MR or those recipients who have an eligible period that is only retroactive. Recipients who are medically needy spenddown eligible.

SERVICES INCLUDED: Rural health clinic, physician, home health, FQHC

PCP PROVIDER TYPES: Family practitioners, general practitioners, internal medicine, OB/Gyn, pediatricians (Provider type employed by a FQHC or rural health clinic may enroll as a PCP.)

FUTURE PLANS: To include non-emergent and inpatient care under the PCP's direction. Non-emergent physician and facility charges will require a referral from the PCP.

Arkansas Medicaid Primary Care Physician Managed Care Program

The Arkansas Medicaid Primary Care Physician Managed Care Program is a statewide program. Under this program, Medicaid recipients must select a primary care physician (PCP) who will provide, through an ongoing recipient/physician relationship, primary care services and health education, monitor on an ongoing basis the recipient's condition, health care needs and service delivery, be responsible for locating, coordinating and monitoring medical and rehabilitation services on behalf of the recipient and refer the recipient for all medically necessary specialty services and other services. Recipient will be restricted to receive services from the PCP or from another provider to whom the recipient was referred by the PCP.

Medicaid recipients participation in the program is mandatory except for certain recipients.

Recipients must select their PCP from any of the following types of physicians: family practitioner, general practitioner (including osteopaths), internal medicine, obstetrician/gynecologist or pediatrician.

The recipient must receive a referral from their PCP before receiving Medicaid services. There are numerous services a recipient can receive without first receiving a referral.

Each PCP is allowed to have up to 1000 Medicaid recipients on their PC case load at one time. PCP's must meet a broad range of requirements in order to be a PCP.

PCPs are paid a per recipient, management fee per month, regardless of whether the recipient was actually seen that month by the PCP.

Arkansas

Inpatient Obstetrical and Routine Newborn Care Services

PROGRAM NAME: Obstetrical and Routine Newborn Care Services	*ORIGINAL IMPLEMENTATION DATE:* April 1, 1995
CONTACT: Binnie Alberius (510) 682-8361	*EXPIRATION DATE:* March 31, 1997
GEOGRAPHIC AREAS: Pulaski, White, and Garland Counties	*NUMBER OF ENROLLEES:* about 800

FFS (PCCM) OR PRE-PAID OR BOTH: N/A

STATUTES UTILIZED: 1915(b)(4) Selective Contracting

STATUTES WAIVED: 1902(a)(1), 1902 (a)(13)(A), 1902(a)(23)

POPULATION CATEGORIES INCLUDED: All Recipients of Childbearing Age

POPULATION CATEGORIES EXCLUDED: All Recipients of Non-childbearing Age

SERVICES INCLUDED: Inpatient Obstetrical and Newborn Inpatient Services

PCP PROVIDER TYPES: N/A

FUTURE PLANS: Our future plans are to continue with the current waiver.

Arkansas Inpatient Obstetrical and Routine Newborn Care Services

On April 1, 1995, the Arkansas Medicaid Program implemented a selective contracting waiver for "Inpatient Obstetrical and Routine Newborn Care Services." The program was conceived with two purposes in mind:

1. Assure adequate access to good quality inpatient hospital obstetrical and routine newborn care services for all recipient groups, and

2. Contain overall expenditures for inpatient hospital obstetrical and routine newborn services reimbursed by the Medical Assistance Program.

The central concept of the waiver is the use of competition and normal market forces to contract with hospitals that achieve these two goals. The waiver allows the State to award an exclusive contract for the provision of obstetric and newborn care in the counties of White and Garland. In Pulaski County, two contracts were awarded. The waiver provisions allow for reimbursement for inpatient OB services in routine cases only to the contract hospital, or in cases of an emergency, as defined by Section 1867, to any Medicaid participating hospital.

California

Selective Provider Contracting Program

PROGRAM NAME: Selective Provider Contracting Program (SPCP)

ORIGINAL EFFECTIVE DATE: September 21, 1982

CONTACT: Virgil J. Toney, Chief
Medi-Cal Operations Division
714 P Street, Room 1560
Sacramento, CA 95814
916-657-0582

EXPIRATION DATE: 2 year continuation through June 22, 1996

GEOGRAPHIC AREAS: The Counties of San Mateo, Solano, Orange, and Santa Barbara

FFS (PCCM) OR PRE-PAID OR BOTH: Fee-For-Service

STATUTES UTILIZED: 1915(b)(4)

STATUTES WAIVED: 1902(a)(1), 1902(a)(5), 1902(a)(13)(A), 1902(a)(23)

POPULATION CATEGORIES INCLUDED: Various counties and select population groups that meet Medi-Cal eligibility; Medi-Cal beneficiaries who are not enrolled in a HMO or COHS are excluded due to operation of a and who have access to County Organized Health System.contracted hospitals.

POPULATION CATEGORIES EXCLUDED: Those State residents currently enrolled in a HMO.

SERVICES INCLUDED: Those services specified in Title 22, California Code of Regulations, commencing with Section 51301 through Section 59998, which are provided in an acute impatient hospital setting.

FUTURE PLANS: As the California Department of Health Services (DHS) expands its Managed Care Program, the beneficiaries served in a fee-for-service environment declines. However, the SPCP will continue to be an integral part of the Medi-Cal Program and there will continue to be significant populations of Medi-Cal beneficiaries not enrolled in a comprehensive managed care plan.

California Selective Contracting

The Waiver for Section 1902(a)(1), 1902(a)(5), 1902(a)(13)(A), and 1902(a)(23), in accordance with Section 1915(b)(4), Title XIX, of the Social Security Act was required in order to implement the Selective Provider Contracting Program (SPCP) and allow California to selectively contract with hospitals to provide inpatient care to Medi-Cal beneficiaries. This form of hospital contracting allows California to purchase health services, provide program enhancements, and manage the Medi-Cal Program in a more efficient and cost effective manner.

The Hospital Contracts and Technical Systems Unit, CDHS, works in conjunction with the California Medical Assistance Commission in selectively contracting with 266 acute care hospitals to provide inpatient care to Medi-Cal beneficiaries at a negotiated per-diem or per-discharge rate. The focus of SPCP is on containing overall expenditures for hospital services reimbursed by the Medi-Cal Program, assuring adequate access, monitoring and reviewing of quality services for all Medi-Cal beneficiaries through competitive rather than regulatory models. Therefore, hospitals are given the opportunity to compete for contracts serving the Medi-Cal population in geographic areas of the state.

California

Medi-Cal Mental Health Care Field Test

PROGRAM NAME: Medi-Cal Mental Health Care Field Test (San Mateo County)

ORIGINAL EFFECTIVE DATE: April 1, 1995

CONTACT: Carol S. Hood
1997Assistant Deputy Director
Systems Implementation and Support
Department of Mental Health
1600 9th Street, Room 250
Sacramento, CA 95814
916-654-5691

EXPIRATION DATE: March 3,

NUMBER OF ENROLLEES: Approximately 53,000

GEOGRAPHIC AREAS: San Mateo County

FFS (PCCM) OR PRE-PAID OR BOTH: Fee-For-Service

STATUTES UTILIZED: 1915(b)(4)

STATUTES WAIVED: 1902(a)(1), 1902(a)(10), 1902(a)(13), 1902(a)(23), 1902(a)(30)

POPULATION CATEGORIES INCLUDED: All categories of federally eligible Medicaid recipients.

POPULATION CATEGORIES EXCLUDED: Undocumented aliens and pregnant women with income levels at 185% of the poverty level (these two groups are only entitled to emergency services and are exempt from waiver restrictions. San Mateo County, however, will be at financial risk for emergency specialty mental health services to these populations). Recipients between the ages of 22 and 64 years who reside in an Institution for Mental Diseases.

SERVICES INCLUDED: Psychiatric inpatient hospital services including hospital based ancillaries; the services of psychiatrists and psychologists; psychiatric long-term care; mental health rehabilitative services; and targeted case management. Mental health rehabilitative services currently include assessment evaluation, collateral therapy, rehabilitation, medication support services, day treatment intensive, day rehabilitation, adult residential treatment services, crisis residential treatment services, crisis

intervention, and crisis stabilization.

PCP PROVIDER TYPES: Mental health providers qualified by Medicare and Medicaid.

FUTURE PLANS: The field test county will be used to evaluate, on a comprehensive basis, several referral tools to be used by primary care physicians, physical health/specialty mental health interface protocols, recipient satisfaction surveys, integrated claims processing system, appropriate outcome measures, and appropriate cost assignment (i.e., determination of what costs and services should be included in the "carve out" of specialty mental health services.) This will provide a laboratory for evaluation of critical design elements prior to statewide implementation.

California San Mateo Organized Health System

The Medi-Cal Mental Health Care Field Test of San Mateo County's objectives are 1) to reduce expected costs by preventing unnecessary and inappropriate utilization of costly inpatient acute care services, and 2) assure adequate access to specialty mental health services for Medicaid recipients in San Mateo County. The waiver is to restrict the number of certain provider types that may provide Medicaid non-emergency specialty mental health services. This waiver allows San Mateo County Mental Health to act as a prudent purchaser of specialty mental health services in order to manage this portion of the Medi-Cal program in a more efficient and cost effective manner.

Since the number of providers under contract with the county may be fewer than the number of willing and eligible (e.g., licensed and certified) providers, beneficiary access to non-emergency specialty mental health services will be restricted to those providers that have contracted with San Mateo County Mental Health. These restrictions will not apply in the following circumstances: emergency services; Medicare/Medicaid crossover patients and persons covered by private health insurance (prior to exhausting their Medicare and/or private health insurance benefits); and, situations when transferring the beneficiary to a contract provider is clinically inappropriate, or not cost effective or efficient.

In the event that non-emergency services are needed, the services would be preauthorized by San Mateo County Mental Health. For emergency services, there will be no preauthorization. Emergency Fee-For-Service/Medi-Cal (FFS/MC) specialty mental health services provided out-of-state will remain in the FFS/MC delivery/payment authorization system to insure the beneficiary's continuing access to these necessary services.

The intent of the waiver is to reduce overall expenditures for specialty mental health services by providing access to the full public mental health system of care, promoting economies of scale, and by providing more efficient and cost effective services. By selectively contracting with the most efficient providers who have developed an expertise in treating persons with serious mental illnesses and emotional disturbances, overall expenditures for specialty mental health services reimbursed through the Medi-Cal Program can be reduced, while assuring adequate access to quality services for Medi-Cal beneficiaries. San Mateo County Mental Health will contract with selected providers that have demonstrated their ability to provide effective, efficient specialty mental health services, through factors such as demonstrated expertise resulting in shorter lengths of stay, competent discharge planning, and coordination with county case management. Costs will be reduced because one of the criteria for selecting providers will be the demonstration of effective and efficient delivery of services.

California

Santa Barbara Health Initiative (SBHI)

PROGRAM NAME:
Santa Barbara Health Initiative (SBHI)

ORIGINAL EFFECTIVE DATE:
Original 1115 waiver granted September 1993; Original 1915(b) waiver granted November 1993

CONTACT: Joseph A. Kelly
Medi-Cal Managed Care Division
714 P Street, Room 650
Sacramento, CA 95814

EXPIRATION DATE:
October 26, 1996

GEOGRAPHIC AREAS: Santa Barbara County

NUMBER OF ENROLLEES: 43,007

FFS (PCCM) OR PRE-PAID OR BOTH: Prepaid Health Insuring Organization

STATUTES UTILIZED: 1915(b)(1)

STATUTES WAIVED: 1902(a)(1), 1902(a)(4), 1902(a)(10), 1902(a)(13)(A), 1902(a)(23), 1902(a)(30). OBRA 1985 provides for a waiver of 1903(m)(2)(A)(ii) and (vi).

POPULATION CATEGORIES INCLUDED: Aid to Families with Dependent Children (AFDC), AFDC-related, Supplemental Security Income (SSI), SSI related, other public assistance, blind/disabled and all medically needy, including share of cost.

POPULATION CATEGORIES EXCLUDED: Certain Medi-Cal aid categories, primarily those with a limited scope benefits.

SERVICES INCLUDED: All Medi-Cal health care services except: dental services, Adult Day Health Care, and home and community-based waiver services. SBHI is not at risk for preventive screening and immunization for children.

PCP PROVIDER TYPES: General Practitioners, Family Practitioners, Pediatricians, Internists, OB/GYNs.

FUTURE PLANS: Continuation of the waiver program.

California Medi-Cal

SBHI contracts with the State to arrange for the provision of Medi-Cal services to the County's eligible Medi-Cal population. SBHI negotiates contracts with providers and administers the program under its Board of Directors. SBHI operates as a primary care network which emphasizes case management as a means of encouraging physician participation, improved access to care, high quality medicine, and efficient treatment patterns. Members are provided entry points to care through primary care providers who are given specific case management responsibilities. The overall operation of the program must provide cost savings when compared to the Medi-Cal fee-for-service system.

Subgoals include the promotion of local administration of the Medi-Cal program, providing financial incentives for providers that promote more effective and efficient use of medical care services, improved long-term treatment planning, and reduce paperwork for participating providers. SBHI involves a broad spectrum of interested community groups, individuals, and local government officials in its operations.

California

Hudman Waiver

PROGRAM NAME: Hudman Waiver

ORIGINAL EFFECTIVE DATE: April 24, 1992

CONTACT: Virgil J. Toney, Jr., Chief
Medi-Cal Operations Division
916-657-0582

EXPIRATION DATE: April 23, 1996 (renew)

NUMBER OF ENROLLEES: 73,300

GEOGRAPHIC AREAS: Statewide

FFS (PCCM) OR PRE-PAID OR BOTH: FFS

STATUTES UTILIZED: 1915(b)(4)

STATUTES WAIVED: 1902(a)(23)

POPULATION CATEGORIES INCLUDED: All long term care residents Medi-Cal eligible

POPULATION CATEGORIES EXCLUDED: State operated Distinct Part/Nursing Facilities

SERVICES INCLUDED: All services specified in Title 22, California Code of Regulations Sections 51335; California Welfare and Institutions Code 14091.21; Hudman vs Kizer Lawsuit, March 1, 1990; 42 CFR 483.12.

FUTURE PLANS: Continue requesting 2 year waiver

California Hudman Waiver

Following a lawsuit in October 1990, the California Department of Health Services (DHS) obtained the Hudman Waiver. This Waiver allows DHS to restrict conditions under which a Medi-Cal beneficiary is able to stay or be transferred to a nursing facility. The Hudman Waiver must be renewed every 2 years. The State Department of Finance conducted an Independent Assessment on the waiver. The placements made in the Free-standing/Nursing Facilities in the 1992/93 and 1993/94 FYs appear to have produced annual savings of approximately $28.4 million and $33.8 million respectively.

California

Geographic Managed Care

PROGRAM NAME:
Geographic Managed Care

ORIGINAL EFFECTIVE DATE:
January 1, 1994

CONTACT: Joseph A. Kelly, Chief
Medi-Cal Managed Care Division
714 P Street, Room 650
Sacramento, CA 95814
916-654-8076

EXPIRATION DATE:
March 31, 1995

GEOGRAPHIC AREAS: Sacramento County

NUMBER OF ENROLLEES:
Medical - 149,982 ; Dental - 143,763

FFS (PCCM) OR PRE-PAID OR BOTH: Prepaid HMOs, partially capitated Prepaid Health Plans, and Prepaid Dental Plans

STATUTES UTILIZED: 1915(b)(1), 1915(b)(2), and 1915(b)(4)

STATUTES WAIVED: 1902(a)(1),1902(a)(10),1902(a)(23),1902(a)(5),and 1902(a)(30).

POPULATION CATEGORIES INCLUDED: Mandatory Enrollment for Aid to Families with Dependent Children (AFDC), no Share of Cost. Voluntary Enrollment for Aged, Blind, and Disabled.

POPULATION CATEGORIES EXCLUDED: Beneficiaries with a Share of Cost or a limited scope of benefits, beneficiaries in need of chronic renal dialysis or major organ transplants or long term care in nursing facilities.

SERVICES INCLUDED: All Medi-Cal covered services are included **except** nursing and Intermediate Care Facility services, home and community based waiver services. Depending on the specific type of plan, the plan may not be at risk for all services.

PCP PROVIDER TYPES: Varies by Plan

FUTURE PLANS: California plans to request a renewal of this waiver

California's Geographic Managed Care

Sacramento County was selected for the development of a Geographic Managed Care (GMC) project in early 1992. The project started April 1, 1994. Under GMC, the California Department of Health Services (DHS) entered into contracts with seven managed care health plans and four managed care dental plans to cover the AFDC population in Sacramento County on a mandatory enrollment basis. These contracts were negotiated by the California Medical Assistance Commission. Currently, enrollment in the dental plans is voluntary. Aged, blind, and disabled beneficiaries eligible for Medi-Cal under the Supplemental Security Income program may voluntarily enroll in one of the managed care plans or choose to receive their health care benefits through the Medi-Cal fee-for-service program.

Under GMC, AFDC beneficiaries are informed of the available managed care plans through the GMC enrollment program, currently contracted to Health Choice, Inc. This program allows the beneficiary to select one of the available managed care plans, or if no selection is made, assigns the beneficiary to a plan.

The enrollment program also provides information regarding primary care physicians (PCP) in each managed care plan, disenrollment procedures, plan grievance procedures, and the state fair hearing process. The AFDC beneficiary is encouraged to choose a primary care physician at the time of enrollment. If no PCP has been selected 30 days after the beneficiary's effective date of enrollment in a managed care plan, the plan will assign a PCP to the beneficiary.

Each managed care plan is required to report encounter data to DHS as well as periodic grievance reports. Beneficiary Satisfaction Surveys have been conducted to determine problems concerning access to and quality of care under the GMC project.

California

Fee-For-Service Managed Care Network (FFS MCN)

PROGRAM NAME: Fee-For-Service Managed Care Network (FFS MCN)	*ORIGINAL EFFECTIVE DATE:* Originally April 1, 1995--Not implemented yet
CONTACT: Joseph A. Kelly, Chief (916) 654-8076	*EXPIRATION DATE:* March 31, 1997
GEOGRAPHIC AREAS: Sonoma, Placer, San Luis Obispo Counties	*NUMBER OF ENROLLEES:* 50,000

FFS (PCCM) OR PRE-PAID OR BOTH: Fee-For-Service

STATUTES UTILIZED: 1915(b)(1)

STATUTES WAIVED: 1902(a)(1), 1902(a)(10), 1902(a)(23), 1902(a)(30)

POPULATION CATEGORIES INCLUDED: Aid to the Families with Dependent Children, Supplemental Security Income.

POPULATION CATEGORIES EXCLUDED: Beneficiaries in need of service for major organ transplants, in skilled nursing facilities, in intermediate care facilities, and in home and community waiver programs.

SERVICES INCLUDED: Outpatient Medi-Cal covered services

PCP PROVIDER TYPES: General Practitioners, Family Practitioners, Pediatricians, Internists, OB/GYNs, Community Clinics, Rural Health Clinics, Federally Qualified Health Centers.

FUTURE PLANS: Possible expansion into other Northern California rural counties

California Managed Care Network

The Fee-For-Service Managed Care Network (MCN) is a pilot project tentatively scheduled for implementation in Sonoma, Placer, and San Luis Obispo Counties. Under the MCN, the State will enter into a contract with one contractor per each pilot area. Eligible Medi-Cal beneficiaries residing in the MCN service area will automatically be enrolled with the program.

The concept of the MCN is based on the premise that access to primary/preventive care will promote the health of the plan member and result in reduced inpatient hospital days and inappropriate emergency room use. Through the development of a provider network, it is expected that increased access to care and continuity of care can be achieved for the betterment of enrolled beneficiaries. MCN will develop provider networks consisting of primary care physicians, speciality physicians, access to inpatient facilities, and development of a 24-hour telephone system for plan members to obtain health care advice. Under this model, the current fee-for-service systems will continue as the reimbursement mechanism.

California

Psychiatric Inpatient Hospital Services Consolidation

PROGRAM NAME: Psychiatric Inpatient Hospital Services Consolidation	*ORIGINAL EFFECTIVE DATE:* March 15, 1995
CONTACT: Carol S. Hood 916-654-5691	*EXPIRATION DATE:* March 14, 1997
GEOGRAPHIC AREAS: Entire state excluding San Mateo, Santa Barbara, and Solano Counties	*NUMBER OF ENROLLEES:* Approximately 5.5 million

FFS (PCCM) OR PRE-PAID OR BOTH: FFS

STATUTES UTILIZED: 1915(b)(4)

STATUTES WAIVED: 1902(a)(1), 1902(a)(23)

POPULATION CATEGORIES INCLUDED: All categories of federally eligible Medicaid recipients are included in the State's waiver program.

POPULATION CATEGORIES EXCLUDED: Undocumented aliens and pregnant women with income levels at 185% of the poverty level (these two groups are only entitled to emergency services and are exempt from waiver restrictions. Counties, however, will be at financial risk for emergency and non-emergency inpatient psychiatric hospital services to these populations). Recipients between the ages of 22 and 64 years who reside in an Institution for Mental Diseases. Medi-Cal enrollees in most Medi-Cal managed care plans. Residents of the field test counties (San Mateo, Santa Barbara, and Solano.)

SERVICES INCLUDED: Services to be provided are psychiatric inpatient services and administrative days only.

PCP PROVIDER TYPES: Mental Health Providers qualified by Medicare and Medicaid.

FUTURE PLANS: It is the State's intention to expand mental health consolidation to include outpatient mental health services by January 1, 1997.

California Psychiatric Inpatient Hospital Services

The Psychiatric Inpatient Hospital Services Consolidation's objective is to reduce costs by slowing the expected rate of growth of psychiatric inpatient hospital services by preventing inappropriate utilization of those services. The basic concept of the waiver is to restrict the number of hospitals that may provide Medicaid non-emergency psychiatric impatient hospital services. This waiver allows California to act as a prudent purchaser of psychiatric inpatient hospital services in order to manage this portion of the Medi-Cal program in a more efficient and cost effective manner.

Since the number of providers under contract with a county may be fewer than the number of willing and eligible (e.g., licensed and certified) providers, beneficiary access to non-emergency psychiatric inpatient hospital services will be restricted to those hospitals that have contracted with the beneficiary's county of residence. These restrictions will not apply in the following circumstances: emergency inpatient psychiatric services; Medicare/Medicaid crossover patients and persons covered by private health insurance, and situations when moving the beneficiary to a contract hospital is clinically inappropriate, or not cost effective or efficient.

In the event that non-emergency services are needed, the services would be preauthorized by the county of residence. For emergency services, there will be no preauthorization. Emergency Fee-For-Service/Medi-Cal (FFS/MC) psychiatric inpatient hospital services provided out-of-state will remain in the FFS/MC delivery/payment authorization system to insure the beneficiary's continuing access to these necessary services.

Certain prepaid health plans and health maintenance organizations within California that serve Medi-Cal beneficiaries are responsible for providing psychiatric inpatient hospital services to their members. These managed care plans will continue to provide these services to Medi-Cal enrollees. As such, counties will not be at risk for serving Medi-Cal managed care members at this time.

The intent of the waiver is to reduce overall expenditures for psychiatric inpatient hospital services by promoting economies of scale, and by providing more efficient and cost effective services. By selectively contracting with the most efficient providers who have developed an expertise in treating persons with mental illness, overall expenditures for psychiatric inpatient hospital services reimbursed through the Medi-Cal Program can be reduced, while assuring adequate access to quality services for Medi-Cal beneficiaries. Counties will contract with selected hospitals that have demonstrated their ability to provide effective, efficient psychiatric inpatient hospital services, through factors such as demonstrated expertise resulting in shorter lengths of stay, competent discharge planning, and coordination with county case management. Costs will be reduced because one of the criteria for selecting providers will be the demonstration of effective and efficient delivery of services

California

Medi-Cal Mental Health Care Field Test (San Mateo Co.)

PROGRAM NAME: Medi-Cal Mental Health Care Field Test (San Mateo Co.)		*ORIGINAL EFFECTIVE DATE:* April 1, 1995
CONTACT:	Carol S. Hood 916-654-5691	*EXPIRATION DATE:* March 31, 1997
GEOGRAPHIC AREAS: San Mateo County		*NUMBER OF ENROLLEES:* Approximately 53,000

FFS (PCCM) OR PRE-PAID OR BOTH: FFS

STATUTES UTILIZED: 1915(b)(4)

STATUTES WAIVED: 1902(a)(1), 1902(a)(10), 1902(a)(13), 1902(a)(23), 1902(a)(30)

POPULATION CATEGORIES INCLUDED: All categories of federally eligible Medicaid recipients.

POPULATION CATEGORIES EXCLUDED: Undocumented aliens and pregnant women with income levels at 185% of the poverty level (these two groups are only entitled to emergency services and are exempt from waiver restrictions. San Mateo County, however, will be at financial risk for emergency specialty mental health services to these populations). Recipients between the ages of 22 and 64 years who reside in an Institution for Mental Diseases.

SERVICES INCLUDED: Psychiatric inpatient hospital services including hospital based ancillaries; the services of psychiatrists and psychologists; psychiatric long-term care; mental health rehabilitative services; and targeted case management. Mental health rehabilitative services currently include assessment evaluation, collateral therapy, rehabilitation, medication support services, day treatment intensive, day rehabilitation, adult residential treatment services, crisis residential treatment services, crisis intervention, and crisis stabilization.

PCP PROVIDER TYPES: Mental health providers qualified by Medicare and Medicaid.

FUTURE PLANS: The field test county will be used to evaluate, on a comprehensive basis, several referral tools to be used by primary care physicians, physical health/specialty mental health interface protocols, recipient satisfaction surveys, integrated claims processing system, appropriate

outcome measures, and appropriate cost assignment (i.e., determination of what costs and services should be included in the "carve out" of specialty mental health services.) This will provide a laboratory for evaluation of critical design elements prior to statewide implementation.

California Mental Health Care Field Test

The Medi-Cal Mental Health Care Field Test of San Mateo County's objectives are : 1) to reduce expected costs by preventing unnecessary and inappropriate utilization of costly inpatient acute care services, and 2) assure adequate access to specialty mental health services for Medicaid recipients in San Mateo County. The waiver is to restrict the number of certain provider types that may provide Medicaid non-emergency specialty mental health services. This waiver allows San Mateo County Mental Health to act as a prudent purchaser of specialty mental health services in order to manage this portion of the Medi-Cal program in a more efficient and cost effective manner.

Since the number of providers under contract with the county may be fewer than the number of willing and eligible (e.g., licensed and certified) providers, beneficiary access to non-emergency specialty mental health services will be restricted to those providers that have contracted with San Mateo County Mental Health. These restrictions will not apply in the following circumstances: emergency services; Medicare/Medicaid crossover patients and persons covered by private health insurance (prior to exhausting their Medicare and/or private health insurance benefits); and, situations when transferring the beneficiary to a contract provider is clinically inappropriate, or not cost effective or efficient.

In the event that non-emergency services are needed, the services would be preauthorized by San Mateo County Mental Health. For emergency services, there will be no preauthorization. Emergency Fee-For-Service/Medi-Cal (FFS/MC) specialty mental health services provided out-of-state will remain in the FFS/MC delivery/payment authorization system to insure the beneficiary's continuing access to these necessary services.

The intent of the waiver is to reduce overall expenditures for specialty mental health services by providing access to the full public mental health system of care, promoting economies of scale, and by providing more efficient and cost effective services. By selectively contracting with the most efficient providers who have developed an expertise in treating persons with serious mental illnesses and emotional disturbances, overall expenditures for specialty mental health services reimbursed through the Medi-Cal Program can be reduced, while assuring

adequate access to quality services for Medi-Cal beneficiaries. San Mateo County Mental Health will contract with selected providers that have demonstrated their ability to provide effective, efficient specialty mental health services, through factors such as demonstrated expertise resulting in shorter lengths of stay, competent discharge planning, and coordination with county case management. Costs will be reduced because one of the criteria for selecting providers will be the demonstration of effective and efficient delivery of services.

Colorado

Primary Care Physician Program (PCCM)

PROGRAM NAME:
Primary Care Physician Program- PCCM

ORIGINAL IMPLEMENTATION DATE:
March, 1982

CONTACT: Kim Gordon

EXPIRATION DATE: January 9, 1997

GEOGRAPHIC AREAS: Statewide

NUMBER OF ENROLLEES: 85,000

FFS (PCCM) OR PRE-PAID OR BOTH: FFS(PCCM) and Prepaid(HMO)

STATUTES UTILIZED: 1915(b)(1)

STATUTES WAIVED: 1902(a)(23), (10), and (1)

POPULATION CATEGORIES INCLUDED: AFDC/AFDC-related; SSI/SSI-related

POPULATION CATEGORIES EXCLUDED: Medicare dual-eligibles

SERVICES INCLUDED: inpatient hospital, outpatient hospital, physician, nursing facility, durable medical equipment, home health, EPSDT, non-emergent care in the Emergency Room

PCP PROVIDER TYPES: physicians, HMO/PHPs, FQHCs, RHCs,

FUTURE PLANS: expand prepaid portion of the waiver

Colorado Primary Care Physician Program

Colorado's physician community was involved from the program's inception, taking an active role in the program's design and development. The PCPP Physician Advisory Committee, organized in 1982, has played a critical role from the beginning. Independent evaluations conducted every two years have consistently concluded that the program has been successful in reducing emergency room usage, improving physician participation and patient access to care, and in realizing significant cost savings. Clients have reported satisfaction with the program in surveys conducted for each evaluation. Future challenges include recruitment and retention of physicians to maintain access to care, achievement of an adequate level of physician reimbursement, and improvement in patient education relative to appropriate use of Medicaid services. Critical to the ongoing success of the program is the continued cooperation between physicians and the State and the leadership of the Physician Advisory Committee.

Colorado

Medicaid Mental Health Capitation and Managed Care Program

PROGRAM NAME: Medicaid Mental Health Capitation and Managed Care Program; selective contracting

ORIGINAL IMPLEMENTATION DATE: July 1, 1995

EXPIRATION DATE: June 30, 1997

CONTACT: Bill Bush (303) 762-4085

NUMBER OF ENROLLEES: 75,000

GEOGRAPHIC AREAS: 5 Mental Health Catchment areas

FFS (PCCM) OR PRE-PAID OR BOTH: Prepaid

STATUTES UTILIZED: 1915(b)(1), (3), and (4)

STATUTES WAIVED: 1902(a)(23), (10), and (1)

POPULATION CATEGORIES INCLUDED: All Medicaid eligibles

POPULATION CATEGORIES EXCLUDED: Medicare

SERVICES INCLUDED: All State Plan Mental Health services

PCP PROVIDER TYPES: Mental Health Assessment and Service Agencies (MHASA's)

FUTURE PLANS: expand Statewide

Colorado Medicaid Mental Health Capitation and Managed Care Program; selective contracting

The goal of the program is to provide management of all mental health care services through the use of contract agencies known as Mental Health Assessment and Service Agencies (MHASAs). Each MHASA is paid a capitated rate, based on several rate cells, for any mental health service required by enrollees. Recipient enrollment in designated catchment areas is mandatory.

The State will select MHASAs through a competitive bid process. Successful bidders will be required to have experience in providing mental health case management; be capable of performing the administrative, financial and data processing functions of managed care; manage the clinical requirements of a mental health managed care system; maintain financial viability; and be able to develop innovative alternatives to hospitalization and inpatient care.

The State will conduct site visits and utilize several of the quality assurance criteria currently used in the public mental health system. The program is expected to save $5.5 million during the first year of the waiver and $15.5 during the second year.

District of Columbia

Managed Care Primary Care Case Management

PROGRAM NAME: D. C Managed Care PCCM	*ORIGINAL IMPLEMENTATION DATE:* April 1, 1994
CONTACT: Jane Thompson (202) 727-0735	*EXPIRATION DATE:* June 30, 1996
GEOGRAPHIC AREAS: Districtwide	*NUMBER OF ENROLLEES:* 92,000

FFS (PCCM) OR PRE-PAID OR BOTH: Both

STATUTES UTILIZED: 1915(b)(1)

STATUTES WAIVED: 1902(a)(10)(B), 1902(a)(23)

POPULATION CATEGORIES INCLUDED: AFDC and AFDC-related

POPULATION CATEGORIES EXCLUDED: All other Medicaid Recipients

SERVICES INCLUDED: All Medicaid services except dental, optometry, eye glasses, nursing home and ICF/MR, general transportation/ambulance, mental health and substance abuse, family planning, hospice

PCP PROVIDER TYPES: Internists, pediatricians, family practitioners, general practitioners, OB/GYN, FQHC, free standing medical clinics, hospital outpatient clinics, neighborhood health centers

FUTURE PLANS: During waiver renewal, D.C. plans to eliminate the PCCM and switch to mandatory HMOs through competitive procurement. D.C. will utilize an enrollment broker.

District of Columbia Managed Care Program

The District of Columbia Medicaid Program began implementation of the D.C. Medicaid Managed Care Program on April 1, 1994. This program is mandatory for most AFDC and AFDC-related recipients, and operates through a freedom of choice waiver. The D.C. Medicaid Managed Care Program allows providers to participate on either a fee-for-service or capitated basis.

Under the D.C. Managed Care Program, each recipient selects or is assigned a primary care physician (PCP) who is either a primary care case manager or a provider within an HMO. The PCP is responsible for providing all primary medical care and will refer or authorize specialty care services. All primary care physicians must provide recipients with 24-hour, 7 days-a-week access and provide management of most non-emergency care. Primary care physicians include general practitioners, family practitioners, internists, pediatricians and OB/GYNs. All Medicaid services are covered under the waiver program except dental services, optometry, nursing home and ICF/MR, transportation, emergency services, psychiatric and/or mental health services, rehabilitation treatment, hospice services, family planning and substance abuse. These services are available to recipients without freedom of choice restrictions.

As of April 1, 1996, 243 primary care physicians participate in the fee-for-service program along with one prepaid health plan and three HMOs. Fee-for-service physicians care for approximately 37,191 recipients, 25,148 are members of the prepaid health plan, and 17,698 are members of the HMOs.

During the summer of 1996, the D.C. Medicaid Managed Care Program will begin phasing into mandatory HMO enrollment. Under the new program. All eligible recipients currently assigned to a PCCM provider will be required to choose an HMO.

To assist recipients in the HMO selection process, the District will contract with an enrollment broker. The primary objective of the enrollment broker will be to increase the number of eligible recipients who make an HMO election within the prescribed time allowed. Those who do not make a choice will be automatically assigned to an HMO.

The District will pay each HMO participating in the new program a monthly capitation rate for each enrollee. The HMO will be financially at risk for the full range of Medicaid-covered services with the exception of mental health and substance abuse services.

Florida

Medicaid Physician Access System (MediPass)

PROGRAM NAME AND TYPE OF WAIVER:
Medicaid Physician Access System (MediPass), 1915 (b) waiver

ORIGINAL IMPLEMENTATION DATE:
October 1, 1991

CONTACT: Charles Kight, (904) 487-2355

EXPIRATION DATE:
December 31, 1995

GEOGRAPHIC AREAS:
31 Countries (as of June 30, 1995)

NUMBER OF ENROLLEES: 215,213

FFS (PCCM) OR PRE-PAID OR BOTH: FFS and $3 monthly management fee per beneficiary

STATUTES UTILIZED: 1915 (b)(1)

STATUTES WAIVED: 1902(a)(10)(b) Comparability of Services; 1902 (a) (23) Freedom of Choice

POPULATION CATEGORIES INCLUDED: Aid to Families with Dependent Children (AFDC), AFDC-related, Supplemental Security Income (SSI) with no Medicare.

POPULATION CATEGORIES EXCLUDED: Recipients that have Medicare coverage; are residing in a nursing facility or ICF/MR; are enrolled in another managed care program; live in an area excluded from the waiver; have an eligibility period that is only retroactive; are eligible as medically needy; or are eligible as foster care children.

SERVICES INCLUDED: Physician; Pharmacy; Hospital Inpatient and Outpatient; Home Health; Laboratory and X-Ray; Ambulatory Surgical Center; Rural Health; Podiatry; advanced Registered Nurse Practitioner; Early and Periodic Screening, Diagnosis, and Treatment; and Chiropractic Services.

PCP PROVIDER TYPES: General Practitioners; Family Practitioners; Pediatricians; Internists; Obstetricians and Gynecologists; County Public Health Units; Rural Health Centers; and Federally Qualified Health Centers.

FUTURE PLANS: The MediPass program is in the process of expanding statewide. By March 31, 1996, all AFDC recipients who have not chosen to enroll in an HMO will be enrolled into MediPass. By June 30, 1996 all SSI-no Medicare recipients who have not chosen in an HMO will be enroled into MediPass.

Florida MediPass Program

The Medicaid Physician Access System (MediPass) is a statewide Primary Care Case Management program that was designed as a managed care alternative to Florida's Medicaid system which serves over a million recipients. the MediPass program is designed to build a strong relationship between a family and their personal physician by assuring adequate access to care, decreasing inappropriate utilization, and reducing costs.

In order to promote continuity of care and a family physician relationship each MediPass recipient enrolls with a physician who is responsible for providing primary care services, after hours access to care, and referral for specialty and hospital services.

In exchange for assuring access to care and providing health care management services. MediPass providers receive $4 per month for each MediPass recipient enrolled in their practice. In addition, the MediPass provider receives fee for service reimbursement form Medicaid for any services he provides to his MediPass recipients.

MediPass is a mandatory program for all eligible recipients have the option of enrolling in a Health Maintenance Organization (HMO) instead of MediPass, however, if the recipient does not choose an HMO, he must be enrolled in MediPass.

The Florida MediPass program is currently, in the process of designing and implementing an Automated Recipient Enrollment System. This program will make mandatory assignment selections taking into account such factors as the age, sex and address for the recipient. The program will also allow for the equitable rotation of assignments among providers, while considering the providers specialty, requested patient cap, and office location. Once implemented statewide, this automated program will substantially reduce the time-consuming and labor-intensive activities involved in the current MediPass enrollment process.

Florida

Prepaid Mental Health Plan Freedom of Choice Waiver

PROGRAM NAME:
Prepaid Mental Health Plan Freedom of Choice Waiver

ORIGINAL IMPLEMENTATION DATE:
July 1, 1993

EXPIRATION DATE: June 30, 1995
(Renewal submitted)

CONTACT : Ken Hemmerly
(904) 487-2618

GEOGRAPHIC AREAS:
Hardee, Highlands, Hillsborough, Manatee, Polk Counties

FFS (PCCM) OR PRE-PAID OR BOTH: Pre-Paid

STATUTES UTILIZED: 1915 (b)(4)

STATUTES WAIVED: 1902 (a)(1), 1902(a)(23), 1902(a)(10), 1915(b)(1)

POPULATION CATEGORIES INCLUDED: AFDC recipients, OBRA children, Foster Care Children, and SSI No Medicare

POPULATION CATEGORIES EXCLUDED: SSI with Medicare, Residence in state mental hospitals, ICF/MR-DD, nursing homes, recipients who elected Medicaid Hospice

SERVICES INCLUDED: Mental Health-Related Inpatient and Outpatient services, Psychiatric services, Community Mental Health Services, and Mental Health Targeted Case Management.

FUTURE PLANS: The original waiver authority was not implemented; a new application was submitted, with an implementation date in early, 1996.

Florida Prepaid Mental Health Plan

This is a two year demonstration project. The state will assign recipients enrolled in MediPass, Florida's PCCM waiver, into this Prepaid Mental Health Plan if the recipients have not elected to enroll in a Medicaid HMO. By the program implementation date, Medicaid HMO's in the five county target area will add mental health services as a covered benefit. Capitation rates vary by eligibility category and age band.

Georgia

Georgia Better Health Care

PROGRAM NAME: Georgia Better Health Care	*ORIGINAL IMPLEMENTATION* October 1, 1993
CONTACT: Charles Beaty (404) 657-9939	*EXPIRATION DATE:* September 30, 1995
GEOGRAPHIC AREAS: 32 of 159 Countries in the Albany Augusta and Dalton areas	*NUMBER OF ENROLLEES:* 137,650

FFS (PCCM) OR PRE-PAID OR BOTH: FFS with $3 PMPM case management fee

STATUTES UTILIZED: 1915 (b)(1)

STATUTES WAIVED: 1902 (a)(1), 1902 (a)(10)(b), 1902 (a)(23)

POPULATION CATEGORIES INCLUDED: AFDC; SOBRA Eligible children; SSI (without M/C) Optional for dually eligibles

POPULATION CATEGORIES EXCLUDED:
SOBRA eligible pregnant women; Recipients with eligiblity of less than 3 months; Recipients with only retroactive eligibility; Children in foster care; Recipients in nursing facility or ICF/MR; Recipients in Hospice; Recipients with profound medical problems or who are being cared for in another case management or medical treatment program may elect not to participate.

SERVICES INCLUDED:
Ambulatory Surgical Center Services;
Children's Intervention Services;
Durable Medical Equipment;
Emergency Room Services;
Home Health Services;
Hospital Inpatient Services;
Hospital Outpatient Services;
In-Home Nursing Services;
Personal Care Services;
Physician Services;

Orthotics and Prosthetics

PCP PROVIDER TYPES: Family Practitioners; General Practitioners; Internists; pediatricians; Gynecologist; Nurse practitioners; Community Health Centers; Rural Health clinics; Primary Care Public Health Department clinics; Primary Care Hospital Outpatient clinics.

FUTURE PLANS: Current plans are to apply for renewal of the waiver and to expand the program throughout the remaining counties of the states over a two year period ending December 31,1997

Georgia Better Health Care Program

Georgia Better Health Care (GBHC) is a program developed by the Department of Medical Assistance (DMA) which matches Medicaid recipients to a primary care physician or provider (PCP). Through Georgia Better Health Care, DMA contracts with primary care physicians and providers to deliver and coordinate Medicaid recipient health care services. GBHC is a primary care case management program approved by the Health Care Financing Administration (HCFA) as a demonstration through waiver under authority of section 1915 (b)(1) of the Social Security Act.

Key goals of the program:

* Primary access to medical care, particularly primary care services
* Enhancing continuity of care through creation of a "medical home"
* Reducing unnecessary use of medical services.

Physician participants is open to general practitioners, family practitioners, pediatricians, general internist, and gynecologist. Physician specialists may also contract as PCPs as long as they agree to provide the services listed below. Nurse practitioners who specialize in family practice, pediatrics, or gynecology are also eligible to become PCPs. Community health department primary car clinics may be enrolled as PCPs as long as the center or clinics has at least one full-time physician or nurse practitioner engaged in delivering primary care services, is open to the public for general medical care at least 30 hours a week, and can provide the services listed below.

PCPs coordinate their members' health care needs by proving the following services:

* Primary care medical services, covered by Medicaid;
* Referral authorization for needed specialty and other covered medical services; and
* Arranged 24 hour-a-day coverage

PCPs receive a monthly case management fee of $3 per member for coordinating members' health care

services, regardless of whether the member is seen. When services are provided, the regular Medicaid fee-for-service reimbursement applies.

Membership in GBHC is mandatory for all Medicaid recipients living within the pilot counties, except for those residing in nursing facilities, personal care homes, mental health hospitals and other domiciliary facilities, as well as Right-from-the-Start Medicaid mothers and other recipients with short-term Medicaid enrollment. Recipients covered by both Medicare and Medicaid are eligible, but not required, to become members of GBHC.

Recipients are given an opportunity to select a primary care case manager. For those who do not make a selection, a computer algorithm is used to assign the recipient to a provider. The assignment process involves up to three steps to ensure an appropriate match. Whenever possible, the recipient is matched based on his or her historical usage or the historical usage of a family member. Lacking any historical usage, the recipient is assigned based on geographic convenience to a primary care provider.

Recipients who are members of GBHC can be identified by a lime green Medicaid card which lists the name, address, and telephone numbers of the member's PCP. Medicaid providers other than the member's PCP generally must obtain authorization form the PCP in order to be reimbursed for services provided to the GBHC member.

Authorization can be obtained by contacting the PCP listed on the GBHC member's Medicaid card. The billing provider must indicate the PCPs authorization number on the claim form. Certain services are exempt form the PCP authorization requirement, as indicated on the back of the member's Medicaid card.

Iowa

MediPASS Medicaid Patient Access to Service System

PROGRAM NAME: MediPASS Medicaid Patient Access to Service System	*ORIGINAL IMPLEMENTATION DATE:* July 1, 1990
CONTACT: Kathy Ellithorpe 515-281-8689	*EXPIRATION DATE:* June 30, 1996 (renewal)
GEOGRAPHIC AREAS: 81 out of 99 counties	*NUMBER OF ENROLLEES:* 67,640

FFS (PCCM) OR PRE-PAID OR BOTH: FFS-PCCM

STATUTES UTILIZED: 1915 (b)(1)

STATUTES WAIVED: 1902 (a)(1), 1902 (a)(10)(b), 1902 (a)(23)

POPULATION CATEGORIES INCLUDED: AFDC and AFDC-related

POPULATION CATEGORIES EXCLUDED: If they have Medicare or other insurance, are residing in a nursing facility or ICF/MR, are enrolled in another managed care program, live in an area excluded from the waiver, have an eligibility period which is only retroactive, are eligible as medically needy, are eligible as foster care children

SERVICES INCLUDED: Inpatient hospital, out-patient hospital, rural health clinic, laboratory, x-ray, EPSDT, family planning, home health, FQHC, physician

PCP PROVIDER TYPES: FP/GP, Internal Medicine, Pediatrics, OB/GYN, Rural Health Centers, FQHCs

FUTURE PLANS: To expand into remaining counties.

Iowa Medipass

Participation in the Iowa Medipass program is mandatory for specified categories of eligibility. Individuals are asked to select one primary care physician to be responsible for providing managed health care to that beneficiary. As an alternative to enrolling with a Medipass physician, beneficiaries may choose to enroll in a Health Maintenance Organization or Prepaid Health Plan, if available. Beneficiaries who do not make a selection will be assigned to one of the three available managed health care options. The Medipass physician will be known as the beneficiaries patient manager and shall receive a fee for the provision of patient management services. The patient manager, under contractual agreement with the State, will provide primary care services and provide or authorize, refer and monitor other necessary medical care covered under the plan. Additionally, the patient manager will be required to provide or arrange for 24 hour per day, seven days per week physician availability to enrolled beneficiaries. The patient manager receives fee-for-service payment for medical services provided and a set monthly fee for the provision of patient management.

Iowa

Mental Health Access Plan (MHAP)

PROGRAM NAME:	*ORIGINAL IMPLEMENTATION DATE:*
Mental Health Access Plan (MHAP)	March 1, 1995
CONTACT:	*EXPIRATION DATE:*
Candice Nardini 515-242-6021	February 2, 1997
GEOGRAPHIC AREAS:	*NUMBER OF ENROLLEES:*
Statewide	190,000

FFS (PCCM) OR PRE-PAID OR BOTH: pre-paid

STATUTES UTILIZED: 1915(b)(1), 1915(b)(3), 1915(b)(4)

STATUTES WAIVED: 1902(a)(1), 1902(a)(10), 1902(a)(23)

*POPULATION CATEGORIES INCLUDED:*AFDC and AFDC related, SSI and SSI related, Medicaid-Medicare dual eligibles under the age of 65

*POPULATION CATEGORIES EXCLUDED:*persons who are enrolled in an HMO, persons receiving care in a Psychiatric Medical Institution for Children, persons age 65 and over, persons in a Mental Health Institute unless the placement was initiated by the MMHCP contrator, persons residing in an ICF/MR, medically needy with a spenddown, persons residing in a hospice

SERVICES INCLUDED:

1. Evaluation, treatment planning and service coordination;
2. Inpatient hospital care for psychiatric conditions;
3. Outpatient hospital care for psychiatric conditions, including emergency room care;
4. 24 hour crisis services including an 800 number hot-line available to all enrollees;
5. Partial hospitalization and day treatment(adults and children);
6. Substance abuse services for persons with a primary diagnosis of mental illness;
7. Psychiatric physician services;
8. Psychologist and social worker services;
9. Supported living services;
10. Community mental health center services;
11. State operated Mental Health Institute services for Eligible Recipients under 21;
12. Targeted case management services;

13. Transportation services;
14. EPSDT

FUTURE PLANS: To continue development of the network and refine process of managing Medicaid mental health services.

Iowa Mental Health Access Plan

The Iowa Mental Health Access Plan (MHAP) is a statewide, capitated plan to deliver comprehensive mental health services to eligible beneficiaries. The contractor, Merit of Iowa is responsible for providing medically necessary mental health services to enrollees. Minimally this includes the same access and scope of services, inpatient, outpatient and emergency as currently provided through the fee-for-service program. Additionally, the contractor is to provide a new set of community-based, supported living services for adults aimed at rehabilitation for persons with chronic mental illness.

Idaho

Healthy Connections

PROGRAM NAME:	*ORIGINAL IMPLEMENTATION DATE:*
Healthy Connections 1915(b)	10/1/93
CONTACT:	*EXPIRATION DATE:*
Jan Cheever, R.N. (208)334-5804	9/30/ 95
GEOGRAPHIC AREAS:	*NUMBER OF ENROLLEES:*
State of Idaho including the following Counties: Cassia, Minidoka, Twin Falls, Benewah, Gooding, Canyon, Kootenai, Nez Perce, Bannock, Power, Bonneville, Clearwater, Ada, and Latah.	21,627 as of 6/95

FFS (PCCM) OR PRE-PAID OR BOTH: FFS (PCCM)

STATUTES UTILIZED: 1915(b)

STATUTES WAIVED: 1902(a)(1) and (23)

POPULATION CATEGORIES INCLUDED: AFDC and AFDC related, SSI and SSI related, Nursing Home pilot project in Region V, and State Supplemental Eligibles

POPULATION CATEGORIES EXCLUDED: NF (except Region V) and ICF/MR residents, those having to travel more than 30 miles or 30 minutes to obtain services, those having an eligibility period that is less than 3 months, those living in an area excluded from the waiver, those having only retroactive eligibility, those who are eligible as medically needy, and those having existing relationships with a primary care physician or clinic that is not participating in the Healthy Connections program.

SERVICES INCLUDED: The same range and amount of services that are available under the usual Medicaid program

PCP PROVIDER TYPES: Internists, General Practitioners, Pediatricians, OB/GYNs, Family Practitioners, Oncologists, General Surgeons, Physician Group Practice Clinics, Rural Health Clinics, Federally Qualified Health Clinics, Indian Health Clinics, Public Health Departments, Urgent Care Centers, and Physician Extenders (i.e. Physician Assistants and Nurse Practitioners)

FUTURE PLANS: Continued geographic expansion beyond the counties that we are now in and we expect to be utilizing the services of prepaid health plans within the next 2 years.

Idaho Healthy Connections

Healthy Connections currently solely operates a primary care case management (PCCM) model. Under this model, a primary care provider receives the standard fee-for-service payments plus a monthly case management fee to serve as "gatekeeper" for the recipients enrolled with that provider. Enrollment into the program is voluntary.

The program was initiated in 1993 when the State received approval of its 1915(b) "freedom of choice" waiver. This waiver must be renewed every two years. As of June 30, 1995, Healthy Connections has enrolled 401 providers and 21,627 recipients. The recipient figure represents 33.7% of the Medicaid recipients eligible for the program.

Indiana

Hoosier Healthwise

PROGRAM NAME: Hoosier Healthwise

ORIGINAL IMPLEMENTATION DATE: 7/1/94

CONTACT: Wendy Bokata
(317) 233-4697

EXPIRATION DATE: 6/30/96

GEOGRAPHIC AREAS: Phased-in Statewide over 3 years

NUMBER OF ENROLLEES: 90,000

FFS (PCCM) OR PRE-PAID OR BOTH: Both PCCM & Risk-based managed care

STATUTES UTILIZED: 1903(m) and 42 CFR 434

STATUTES WAIVED: 1902(a)(1); 1902(a)(10)(B); 1902(a)(23)

POPULATION CATEGORIES INCLUDED: AFDC & related groups

POPULATION CATEGORIES EXCLUDED: Aged, Blind & Disabled

SERVICES INCLUDED: Inpatient, Outpatient, Lab/X-ray, EDSDT, physician services, FQHC services, family planning, home health, dental, pharmacy, transportation

PCP PROVIDER TYPES: Pediatrician, Internist, Family Practice, OB/GYN, General Practice

FUTURE PLANS: Voluntary HMO plan for disabled recipients.

Indiana Hoosier Healthwise

Effective July 1, 1994, Indiana's Office of Medicaid Policy and Planning began implementation of a statewide mandatory managed care program called Hoosier Healthwise. Medicaid recipients eligible for the program include the AFDC and AFDC-related pregnant women and children population. The goals of Hoosier Healthwise are to:

- Ensure access to primary and preventive care
- Improve access to all necessary health care services

- Encourage quality, continuity, and appropriateness of medical care
- Provide medical coverage in a cost-effective manner

Mandatory recipient enrollment in Hoosier Healthwise is being phased in via county groupings over a three-year period. The second group of counties began mandatory enrollment on July 1, 1995, and the third group will begin July 1, 1996. Mandatory enrollment occurs on determination of eligibility for Medicaid or at redetermination. Education and enrollment information is facilitated by personal contact with a Benefit Advocate located in the local Division of Family and Children offices. As of October 1995, approximately 100,000 recipients have been enrolled in Hoosier Healthwise.

Hoosier Healthwise is made up of two delivery systems: Primary Care Case Management (PCCM) and Risk-Based Managed Care (RBMC). Eligible recipients in mandatory counties are required to enroll with a Primary Medical Provider (PMP) in one of the two systems and, if enrolling with a PMP in the RBMC system, will also be enrolled with a managed care organization (MCO). Eligible recipients in voluntary enrollment counties may enroll by selecting a physician who has enrolled in Hoosier Healthwise as a PMP. If a recipient in a mandatory county fails to make a timely PMP selection, a PMP is auto-assigned. PMPs may participate in both systems, but are only open to enroll recipients in one system at a time.

PMP physicians provide preventive and primary medical services, as well as authorization and referral for most medically necessary specialty services. These services, called PMP services, include physician, hospital inpatient and outpatient services, and some ancillary services. Non-PMP services include emergency care, mental health, family planning, dental, podiatry, NF and ICF/MR, vision care, methadone maintenance, sexually transmitted disease clinic services, HCBS waiver services, healthy start, pharmacy, chiropractic, and transportation services.

In the PCCM system, PMPs assume no financial risk and are paid on a fee-for-service basis plus a $3 monthly administration fee for each enrolled recipient under their care. In the RBMC system, currently contracted MCOs operate in two or more of three regions in the state. Each MCO must demonstrate its ability to develop a provider network that will eventually cover the entire region. MCOs assume financial risk for developing and managing a health care delivery system that arranges for or provides Medicaid-covered services. The State pays a monthly capitation fee for each enrolled recipient. Services not included in the PCCM or RBMC systems are paid on a fee-for-service basis.

Kansas

Health Connect (PCCM) Prime Care Kansas (HMO)

PROGRAM NAME:
Health Connect (PCCM)
Prime Care Kansas (HMO)

ORIGINAL IMPLEMENTATION DATE:
January 1, 1984

CONTACT: Jim Nash (816) 426-3406

EXPIRATION DATE: January 30, 1997

GEOGRAPHIC AREAS: Wyandotte
Sedgwick, Johnson, Shawnee,
Leavenworth, Douglas, Saline, Ellis, Ness

NUMBER OF ENROLLEES:
55,887 PCCM, 0 HMO

FFS (PCCM) OR PRE-PAID OR BOTH: Both

STATUTES UTILIZED: 1915(b)(1), 1915(b)(4)

STATUTES WAIVED: 1902(a)(23)

POPULATION CATEGORIES INCLUDED: AFDC, AFDC-related (PLE only), SSI (PCCM only), SSI-related (PCCM only)

POPULATION CATEGORIES EXCLUDED: Medicare covered, other insurance (PCCM only), in an ICF/MR or nursing facility, enrolled in another Medicaid managed care plan (PCCM only), foster care eligible, HCBS recipient, excessive travel required to obtain services (HMO only), retro eligibility (HMO only)

SERVICES INCLUDED: All Title XIX services except dental, psychiatry, podiatry and chiropractic (PCCM). All Title XIX services except nursing home and ICF/MR, dental, psychiatry, family planning, home and community-based waivered services, sterilizations and abortions, heart, liver and bone marrow transplants (inpatient hospital services), State mental health institution services, mental health (behavior management, community mental health clinics, partial hospitalizations), nursing facility for mental health, and head injury rehabilitation facilities.

PCP PROVIDER TYPES: General practitioner, family practitioner, internal medicine, ob/gyn, pediatrician, ARNP, FQHC, RHC

FUTURE PLANS: Continue expansion of HMO contracting.

Kansas Health Connect and Prime Care

The PCCM, currently called Health Connect, was established by the Kansas Department of Social and Rehabilitation Services (SRS) to allow access to top quality medical care in an efficient and economical manner. The Health Connect physician, as the case manager, agrees to provide medical care to a selected group of Medicaid/MediKan recipients, or when necessary, refer the patient to another provider. The Health Connect case managers are defined as physicians who are in general practice, family practice, internal medicine, obstetrics and gynecology or pediatrics. The physician case manager is paid a monthly management fee for each recipient under his management, plus the normal fee-for-service allowances for medical services the recipients require. Recipients are restricted to the case manager and may not receive medical services with out the case manager's written approval. There are only two exceptions: (I) emergency services; and (ii) services exempt from PCCM referral.

The goals of Health Connect are to better manage recipient use of medical services; provide access to primary medical care by the physician case manager on a 24-hour per day basis; increase physician involvement in the Medicaid/MediKan Program; and contain costs in Medicaid/MediKan with out a reduction in medically necessary services.

The waiver was recently amended to include the program Prime Care Kansas. The basic concept of this waiver is to enroll Medicaid recipients in HMOs which will provide or prior authorize all primary care services and all necessary specialty services. The HMO is responsible for monitoring the health care and utilization of non-emergency services. Neither emergency nor family planning services are restricted under the waiver.

The HMO will assist the participant in gaining access to the health care system and will monitor on an ongoing basis the participant's condition, health care needs, and service delivery. The plan will be responsible for locating, coordinating, and monitoring all primary care and other medical and rehabilitation services on behalf of recipients enrolled in the plan. The waiver's intent is to enhance existing provider-patient relationships and to establish a relationship where there has been none. It will enhance continuity of care and efficient and effective service delivery.

Kentucky

Kentucky Patient Access and Care System (KenPAC)

PROGRAM NAME: Kentucky Patient Access and Care System (KenPAC), 1915(b)(1)

ORIGINAL IMPLEMENTATION DATE: February 1, 1986

CONTACT: Larry A. McCarthy
(502) 564-8196

EXPIRATION DATE: August 21, 1997

GEOGRAPHIC AREAS: Statewide

NUMBER OF ENROLLEES: 283,000

FFS (PCCM) OR PRE-PAID OR BOTH: PCCM

STATUTES UTILIZED: 1915(b)(1)

STATUTES WAIVED: 1092(a)(1), 1902(a)(10)(B), 1902 (a)(23)

POPULATION CATEGORIES INCLUDED: AFDC and AFDC-related

POPULATION CATEGORIES EXCLUDED: aged, blind, and disabled categories of recipients; nursing facility residents; mental hospital patients; foster care cases; refugees; all spend-down cases; and all Lock-In cases.

SERVICES INCLUDED: inpatient hospital, outpatient hospital, physician services, pharmacy services, rural health services laboratory services, home health services, primary care center services, nurse anesthetist services nurse practitioner services, ambulatory surgical services, durable medical equipment services, and other laboratory and x-ray services.

PCP PROVIDER TYPES: general practitioners, family practitioners, pediatricians, obstetricians, gynecologists, internists, primary physician clinics, primary care centers, and rural health clinics.

FUTURE PLANS: 1915 (b)(1) will be subsumed by the 1115 Wavier

Kentucky KenPAC

KenPAC is a statewide primary care case management program which was developed by the Cabinet for Human Resources through its Department for Medicaid Services. The goals of KenPAC are:

-Assuring needed access to health care
-Providing for continuity of care
-Preventing unnecessary utilization and costs
-Strengthening the patient/physician relationship

KenPAC, as an enhancement to the Kentucky Medicaid Program provides Medicaid recipients with a primary physician or family doctor. The primary physician is responsible for providing or arranging for the recipient's primary care and for referral for other medical services.

UNIQUE FEATURES: There are currently 283,000 Medicaid recipients participating in KenPAC many of which have for the first time assurance of needed access to health care.

The Medicaid Access and Cost containment Project, Section 1115 Wavier Demonstration Project has only recently been approved by HCFA on October 6, 1995.

Because the tentative implementation date is scheduled for July 1, 1996, we are unable to provide you with any information at this time.

Louisiana

Community Care Program

PROGRAM NAME: Community Care Program *ORIGINAL IMPLEMENTATION:* June 1, 1992

CONTACT: Helene Robinson (504) 342-9535 *EXPIRATION DATE:* June 25, 1997

GEOGRAPHIC AREAS: Phasing in Statewide *NUMBER OF ENROLLEES:* 45,181

FFS (PCCM) PREPAID OR BOTH: PCCM

STATUTES UTILIZED: 1915(b)(1)

STATUTES WAIVED: 1902(a)(1), 1902(a)(23)

POPULATION CATEGORIES INCLUDED: All Title XIX eligibles

POPULATION CATEGORIES EXCLUDED: Have Medicare, in N/H or ICF/MR, enrolled in another managed care program, have eligible period that is less than 3 months, live in area excluded from waiver, medically needy, foster children, aged, residents of inpatient psychiatric facility, persons eligible because of presumption eligible, clients of Office of Youth and Development, and refugees.

SERVICES INCLUDED: Inpatient hospital, outpatient hospital, rural health clinic, laboratory, x-ray, EPSDT, physician, FQHC

PCP PROVIDER TYPES: Physicians, rural health clinics, FQHC, Osteopath

FUTURE PLANS: Future plans include enrollment in HMOs on a voluntary basis within the next year. We also have a pending 1115 waiver request which would allow us to implement mandatory enrollment in managed care for most eligibility groups. There would be a choice from at least two HMOs.

Louisiana CommunityCARE

CommunityCARE is a Primary Care Case Management (PCCM) managed care program administered by Louisiana Medicaid. The program provides Medicaid recipients in designated rural parishes with a physician, Federally Qualified Health Center (FQHC) or rural health clinic as the recipients' primary care physician (PCP). Louisiana Medicaid operates CommunityCARE utilizing a freedom of choice waiver under the authority of section 1915(b)(1) of the Social Security act. The Program is operational in 20 parishes.

For their services, CommunityCARE providers receive a $5.00 per month per patient management fee in addition to the regular Medicaid fee-for-service payment for services provided by the PCP. In addition to meeting Medicaid enrollment criteria, participating PCPs must have hospital admission privileges, provide 24-hour access, provide or arrange for EPSDT services, and give written referrals for inpatient and outpatient hospital services, speciality physician services, lab and x-ray, home health, durable medical equipment and rehabilitation center services. Providers of these services cannot receive payment without a referral from the PCP.

As the care manager, the PCP is responsible for managing all facets of the recipient's health care. This responsibility includes providing patient education preventive care, maintenance and acute care, and referral to specialists when necessary. The population includes AFDC and SSI recipients.

CONTACT: Helene Robinson
Bureau of Health Services Financing
Managed Care Unit
P. O. Box 91030
Baton Rouge, Louisiana 70821-9030

Massachusetts

MassHealth Managed Care

PROGRAM NAME: MassHealth Managed Care	*ORIGINAL IMPLEMENTATION DATE:* January 1, 1992
CONTACT: Michael Bailit (617) 348-5510	*EXPIRATION DATE:* April 25, 1997
GEOGRAPHIC AREAS: Statewide	*NUMBER OF ENROLLEES:* 460,000

FFS (PCCM) OR PRE-PAID OR BOTH: BOTH an HMO Program and a PCCM with a fully capitated Mental Health and Substance Abuse Carve-out Program.

STATUTES UTILIZED: 1915(b)

STATUTES WAIVED: 1902(a)(23)

POPULATION CATEGORIES INCLUDED: AFDC, AFDC-related, SSI, SSI-related, and Refugee Resettlement Program.

POPULATION CATEGORIES EXCLUDED: Recipients with TPL, recipients over age 65, recipients who are institutionalized , recipients eligible for retroactive eligibility only, recipients who are presumptively eligible during the period of presumptive eligibility, aliens eligible solely for emergency services, recipients eligible as a result of spend down, and recipients receiving hospice care.

SERVICES INCLUDED: PCCM - All Medicaid covered services. HMO Program - Medicaid benefit package includes most, but not all, non-long term care Medicaid services, including mental health and emergency services. HMOs are required by contract to assist members obtain non-capitated services when needed (for example, home health services and durable medical equipment).

PCP PROVIDER TYPES: Individual physicians, physician groups, community health centers, and hospital outpatient departments.

FUTURE PLANS: 1115 Waiver has been approved by HCFA. State legislature is considering enabling legislation.

MassHealth Managed Care

The Massachusetts Medicaid Program offers recipients a choice of two managed care programs: the Primary Care Clinician Plan (PCCP) and the HMO Program.

The PCCP contracts with 1,324 primary care entities, including individual physicians, physician groups, community health centers, and hospital outpatient departments. The primary care entities serve as gatekeepers to ensure recipients access the most appropriate care for their medical condition.

The PCCP also has a fully-capitated carved-out mental health and substance abuse (MH/SA) component. The MH/SA is administered by a mental health managed care plan under contract with the state. The MH/SA was the first statewide program of its kind in the United States and has been widely recognized for its innovation, as well as its programmatic and financial success. Inpatient utilization has been reduced, and a broad continuum of flexible diversionary services have been developed to better address the needs of recipients. Together, the PCCP and the MH/SA represent a comprehensive benefit plan.

The HMO Program offers all recipients a choice of 12 HMOs. In addition, recipients with end-stage AIDS or severe physical disabilities may select one of the two HMO plans specifically designed to serve the needs of these special populations. The HMOs provide most Medicaid covered services in exchange for a monthly capitation payment from the state. The HMO is obliged by contract to assist recipients access needed services that are covered by Medicaid but are not included in the capitation.

The HMO Program consists a variety of model-types, including Independent Practice Associations (IPA), staff, group, network and mixed model plans. HMO penetration is distributed throughout the state and current capacity is ample to enroll every Medicaid recipient in an HMO.

Recipients who fail to choose either an HMO or the PCCP are automatically assigned to the PCCP and paired with a provider that the recipient has seen in the past. Beginning in November, 1995, the State will begin assigning some recipients who do not exercise their choice to the HMO program.

Maryland

Diabetes Care Program

PROGRAM NAME: Diabetes Care Program	*ORIGINAL IMPLEMENTATION DATE:* June 1, 1991
CONTACT: Lavern Ware (410) 225-5220	*EXPIRATION DATE:* February 21, 1998
GEOGRAPHIC AREAS: Statewide	*NUMBER OF ENROLLEES:* 2,415

FFS (PCCM) OR PRE-PAID OR BOTH: PCCM (FFS)

STATUTES UTILIZED: 1915(b)(1), 1915(b)(2)

STATUTES WAIVED: 1902(a)(10)(B), 1902(a)(23)

POPULATION CATEGORIES INCLUDED: AFDC, SSI, Medically Needy, SOBRA Children

POPULATION CATEGORIES EXCLUDED: Recipients with Medicare Coverage; Nursing Home and ICF/MR Residents; Individuals who have managed care coverage; Retroactive Eligibility Only; SOBRA Women

SERVICES INCLUDED: All Medicaid Services and certain diabetes-related services and supplies

PCP PROVIDER TYPES: General practitioners, internists, pediatricians, family practitioners, nurse practitioners, FQHCs, Rural Health Clinics, Hospitals, Children & Youth Clinics

FUTURE PLANS: To include increasingly chronically ill diagnosed diabetics in program and to expand availability of health education classes.

Maryland Diabetes Care Program

The Diabetes Care Program (DCP) is available to a recipient who has diabetes, has been discharged from a hospital inpatient stay for a diabetes-related diagnosis, and meets other specific requirements (e.g., is not a Medicare beneficiary, a nursing facility patient, or HMO enrollee). Enrollment is voluntary, but once enrolled in DCP, the recipient must obtain health care from a single diabetes primary care provider (PMP) or upon referral from that provider to other providers. Unlike the Corrective Managed Care Program, an enrollee is not restricted to a single pharmacy. The program is designed to operate statewide under a HCFA waiver and was implemented on June 1, 1991.

Enrollees may receive additional services which are not available to non-enrollees. These services include diabetes outpatient education, nutritional counseling, and therapeutic footwear, as well s items of disposable medical supplies and durable medical equipment usually available only to insulin-dependent diabetic recipients. Recipients enter the program by signing a voluntary enrollment form which may be obtained from the program or from hospital discharge staff. Hospitals are required to notify the DCP of every recipient who is discharged after inpatient treatment of a diabetes-related condition. Recipients are enrolled for an indefinite period of time but may change their primary medical provider or may terminate their participation at any time.

A diabetes primary medical provider (PMP) must meet special requirements in addition to meeting the basic Maryland Medicaid qualifications as a physician services provider in a private or group practice, a nurse practitioner, or a free-standing clinic. Each primary medical provider must sign an agreement to provide coordination of health care for assigned recipients and to maintain a minimum number of scheduled office hours and 24 hour/seven day a week coverage. A monthly managed care fee of $20 per enrollee is paid to the PMP irrespective of service delivery during the month. Diabetes nutrition counseling must be rendered to program participants by licensed nutritionists or dieticians, and diabetes outpatient education must be furnished by a provider certified by the Office of Chronic Disease Prevention of the Maryland Department of Health and Mental Hygiene. There are 500 primary care providers statewide participating in the Program.

With the most recent renewal (2/96), plans are to increase enrollment with patients who have two emergency room visits within a year for diabetic related illnesses, and patients presently enrolled in the High Cost User's Waiver. Generally, this population is more expensive to treat, and expectations are that Medicaid expenditures can be reduced further by providing the diabetic care program services. The prior authorization requirements for waiver participants are being eliminated to facilitate the use of certain ancillary services related to diabetes, and education class availability will be expanded to improve recipient utilization of the program and services.

Maryland

Maryland Access to Care (MAC)

PROGRAM NAME: Maryland Access to Care (MAC)

ORIGINAL IMPLEMENTATION DATE: December 1, 1991

CONTACT: Dawn L. Grosshandler (410) 225-5444

EXPIRATION DATE: May 24, 1996

GEOGRAPHIC AREAS: Statewide

NUMBER OF ENROLLEES: 198,000

FFS (PCCM) OR PRE-PAID OR BOTH: PCCM with enhanced FFS for case management

STATUTES UTILIZED: 1915(b)(1)

STATUTES WAIVED: 1902(a)(1), 1902(a)(10)(B), 1902(a)(23)

POPULATION CATEGORIES INCLUDED: AFDC, SSI , SOBRA Children

POPULATION CATEGORIES EXCLUDED: Pregnant Women , Recipients Enrolled in Managed Care, Recipients for Whom State Pays Medicare Premiums, Foster Care, Subsidized Adoptions, Recipients in State Institutions

SERVICES INCLUDED: Comprehensive primary health care services

PCP PROVIDER TYPES: Family Practitioners, General Practitioners, Pediatricians, Medical Internists, Nurse Practitioners, Free Standing Clinics, Hospital Outpatient Departments

FUTURE PLANS: No major changes. Plans are to implement a statewide managed care program during the next renewal period.

Maryland Access to Care

The Maryland Access to Care (MAC) Program links Medical Assistance recipients with primary medical providers (PMPs) who provide primary health care and serve as gatekeepers for the provision of specialty care. The included physicians engage in family practice, general practice, pediatrics, and internal medicine, as well as nurse practitioners. Under certain circumstances, another type of specialty physician may be designated as a MAC PMP when it is in the best interest of, and requested by, the recipient. PMPs must have regular office hours, 24 hour call and coverage arrangements, and participate in the EPSDT Program if they serve children. By stressing access to primary care, MAC seeks to promote quality, continuous care and provide recipients with a "medical home". Unlike other States with similar programs, Maryland does not pay a monthly per person management fee. Instead, concurrent with the start of the MAC Program, office visit fees for primary care were raised by an average of 50%. The decision to raise fees rather than have a monthly per person payment was made after consulting with the leadership of the Maryland physician community.

The MAC Program began on December 9, 1991. MAC is operational under a HCFA waiver and applies statewide to designated categories of recipients. The MAC Program applies to more Medicaid recipients with 2 major exclusions: (1) Recipients enrolled in a Medicaid HMO, and (2) Recipients for whom the State pay Medicare premiums. There are additional exclusions for those enrolled in other Medicaid managed care programs, those in State institutions and foster care, and subsidized adoption cases. A complete evaluation of the Program will be conducted by Project Hope under a grant from the Health Care Financing Administration.

Maine

PrimeCare

PROGRAM NAME: PrimeCare

ORIGINAL IMPLEMENTATION DATE: June 1, 1994

CONTACT:
Christine Zukas-Lessard
(207)287-3827

EXPIRATION DATE: May 31, 1996

GEOGRAPHIC AREAS:
Kennebec and Somerset Counties;
will be implemented in other counties

NUMBER OF ENROLLEES: 250

FFS (PCCM) OR PRE-PAID OR BOTH: FFS PCCM, with $3 Case Management Fee

STATUTES UTILIZED: 1915(b)(1)

STATUTES WAIVED: 1902(a)(1), 1902(a)(10)(b), 1902(a)(23)

POPULATION CATEGORIES INCLUDED: AFDC, AFDC-related, transitional Medicaid eligibles, SOBRA eligible children, pregnant women

POPULATION CATEGORIES EXCLUDED:
SSI, SSI-related
beneficiaries who are covered by Medicare, except for Medicaid-only purposes
beneficiaries who are covered by other insurance
beneficiaries who are residents of a Nursing Facility or ICF/MR
who are enrolled in another managed care program
who have to travel more than 30 minutes to obtain services
who have an eligibility period that is less than 3 months
who live in an area excluded from the waiver
who have an eligibility period that is only retroactive
who are eligible as medically needy
who are eligible as foster care children
residents of a private, non-medical institution
residents of a State Mental Institution or jail
recipients who are better served by a non-primary care provider, i.e. specialists
recipients who are exempt because of medical necessity
Others: homeless populations, migrant farm workers.

SERVICES INCLUDED:
All Medicaid Covered Services
Targeted Case Management Services
Home and Community Based waiver services
Community Support services (for persons with a severe Mental Illness)
Developmental and Behavioral Evaluation Clinic services
Day Habilitation services for persons with Mental Retardation
Day Health services (for adults with long-term care needs)
Early Intervention services
EPSDT services, outreach and enrollment services only
Family Planning services
Hearing Aids and related services
Home-based Mental Health services
Licensed Clinical Social Work services
Mental Health Clinic services
Optician services
Private Duty Nursing and Personal Care services (for persons with long term care needs)
Private non-medical institution services
Psychological services
Rehabilitative services (for persons with brain injuries)
Substance Abuse treatment services
Nurse-Midwife services
VD Screening Clinic services
Annual Gynecological exam
No restrictions on Emergency care

PCP PROVIDER TYPES:
Family Practice Providers
General Practice
Pediatricians
Rural Health Clinic Providers
FQHCs
Nurse Practitioners
Ambulatory Care Center providers
Hospital-based Outpatient Clinic providers
Physician Assistants

FUTURE PLANS:
Will function side-by-side with HMO choice initiative. This will be implemented in Kennebec and Somerset counties (HMO choice will replace PrimeCare). Simultaneously, in the first year of HMO choice, PrimeCare will be expanded to those counties not included in the PrimeCare initiative.

Michigan

Capitated Clinic Plan

PROGRAM NAME:	*ORIGINAL IMPLEMENTATION DATE:*
Capitated Clinic Plan	approx. 1983
CONTACT:	*EXPIRATION DATE:*
Mark Cohen (517) 335-5116	5/95 with request for extension
GEOGRAPHIC AREAS:	*NUMBER OF ENROLLEES:*
Statewide	37,351

FFS (PCCM) OR PRE-PAID OR BOTH: Pre-paid

STATUTES UTILIZED: 1915(b)(1)

STATUTES WAIVED: 1902(a)(1), 1902(a)(10)(B), 1902(a)(23), 1902(a)(30)

POPULATION CATEGORIES INCLUDED: All Medicaid Eligibles

POPULATION CATEGORIES EXCLUDED: Spend-down categories, Title V/Tile XIX, Recipients in Nursing Homes

SERVICES INCLUDED: All ambulatory services except for dental

Michigan Capitated Clinic Plan

Since 1983, the Medical Services Administration (MSA) has contracted with Clinic Plans (CP) to provide twenty four hour access for Medicaid covered health services, with the exception of dental, long-term-care, and in-patient hospitalization. To receive long-term-care services the recipient must disenroll from the CP and receive services in a fee-for-service environment. For inpatient hospitalization, the physician services and ancillary fees are covered by the CP but the hospital facility costs are billed to Medicaid. A recipient can receive dental services and remain a CP member. A CP is responsible for dental-related services covered by Medicaid that are not provided by a general dentist. These services include prescription drugs, laboratory, radiology, oral surgeon fees, and out-patient hospitalizations. All other dental related services provided and performed by the dentist are billed to Medicaid on a fee-for-service basis by the dentist.

The Clinic Plan increases recipient accessibility to Medicaid providers. In addition, recipients do not have any co-payments except for dental over 21, while they are a member of a Clinic Plan.Clinic Plans are a federally approved waiver program. On-site inspections for contract compliance are conducted annually by MSA staff. The Physician's Review Organization of Michigan, Inc. (PROM), is contracted to do an annual review for Quality Assurance and review their medical records. Previously, this review was completed by Michigan Peer Review Organization (MPRO) and no discrepancies were reported.

The CPs are paid a monthly capitation rate per enrollee. These rates are based on the fee-for-service costs of a like population for covered services in the CP's service area. However, unlike HMOs, the capitation fee does not include reimbursement for inpatient hospital services. DSS pays hospitals directly for admissions that are authorized by the Clinic Plan. Contractors are then eligible to earn an inpatient bonus if the total cost of inpatient care is less than 80 percent of what would have been expected for the case mix of enrollees.

Clinic Plan contracts are renewed on a yearly basis. Yearly changes are made as mandated by Federal and State laws. The contracts do not go out for bids.

Some CPs market door to door in areas known to have a high concentration of Medicaid recipients. The marketing representatives utilized by the Plan must be licensed as Health Benefit Agents.

Contracts with Clinic Plans have resulted in an estimated 12% savings to the Medicaid program. The MSA has contracts with five Cps.

Michigan

Physician Sponsor Plan

PROGRAM NAME:	*ORIGINAL IMPLEMENTATION DATE:*
Physician Sponsor Plan	Approximately 1982
CONTACT:	*EXPIRATION DATE:*
Kyle Boyer-Straley (517) 335-5549	April 1, 1997
GEOGRAPHIC AREAS:	*NUMBER OF ENROLLEES:*
Statewide	468,095

FFS (PCCM) OR PRE-PAID OR BOTH: FFS and $3.00 Case management fee

STATUTES UTILIZED: 1915(b)(1)

STATUTES WAIVED: 1902(a)(1), 1902(a)(10), 1902(a)(23), and 1902(a)(7)

POPULATION CATEGORIES INCLUDED: The waiver is limited to the following target group of recipients:

AFDC
AFDC-related
SSI
SSI-related
Other voluntary enrollments, e.g. Medicare, clients with other insurance.

POPULATION CATEGORIES EXCLUDED: The waiver excludes the following recipients:

Medicare coverage, except for purposes of Medicaid-only services
Other full coverage insurance
Residing in a nursing facility ICF/MR
Enrolled in another managed care program
Live in an area excluded from the waiver or adequate access is still underdeveloped
Have an eligibility period that is only retroactive
Are eligible as foster care children; or voluntary enrollment
Spend down clients
Dually enrolled Children's Special Health Care Services and Medicaid program eligibles

SERVICES INCLUDED: All Medicaid covered services will be prior authorized under the waiver with the exception of the following services:

Dental services
Emergency services
Psychiatry services obtained through Community Mental Health
Ophthalmology services
Obstetrical services
Pharmacy services
Podiatry services
Nursing home and ICF/MR services
Durable medical equipment
General transportation and ambulance/wheelchair van services
Chiropractic services
Immunizations
STD
Family Planning Services
School Based Services

PCP PROVIDER TYPES:

General Practice
Certified Pediatric and Certified Family Practice Nurse Practitioners who have a collaborative agreement with a physician.

Additional types of specialty physicians may perform as PCPs: Pediatricians, Family Practitioners, Internists, OB/GYN, and any other specialist who either has a primary care mode of practice or who agrees to provide primary care to enrollees.

FUTURE PLANS: Enroll dually eligible Children's Special Health Care Services and Medicaid eligibles in a new managed care plan, Physician sponsor Plan Plus.

Capitate Physician Sponsor Plan

Michigan Physician Sponsor Plan

The Physician Sponsor Plan was implemented 7-1-82 in Wayne County, Michigan. The plan was devised by the Michigan State Medical Society and the Michigan Association of Osteopathic Physicians and Surgeons in response to a legislative request for a proposal outlining an alternative reimbursement approach. The costs of Medicaid were rising at a rate exceeding that of inflation. Physicians were paid on a fee-for-service basis.

The Plan

The PSP proposal submitted by the medical societies retained fee-for-service reimbursement but differed significantly from the existing delivery system. Under the PSP, each client selects a primary care physician who becomes the client's physician sponsor. The sponsor either directly renders or authorizes most medical services. Some services do not require an authorization; these are: emergency services, chiropractic, podiatric, hearing, vision, family planning services obtained at a family planning clinic, nurse midwife and dental. Radiology, pathology and pharmacy services do not require direct authorization but must be ordered by a physician and the physician must have an authorization. The sponsor receives a case management fee of $3 per month per enrolled recipient (to a maximum of $3,000 per mont). This fee is to offset the cost of maintaining a 24 hour access system, reviewing periodic utilization reports and establishing a referral mechanism. Continuation of the fee is contingent upon program savings. The selected sponsor's name will appear on the client's Medicaid card and remain there until either the sponsor or the recipient requests a change.

The Contract

All doctors in and around the Wayne County demonstration area were sent an application. Any doctor can be a sponsor but the doctor must have a primary care mode of practice or agree to render primary care to his/her enrollees. The contract is a one year, renewable document. It outlines the responsibilities of both the physician sponsor and the department. It also details contract sanctions.

Monitoring

To assess the impact of the P.P. upon recipients, the DSS has contracted with an independent agency to monitor the implementation and the effect upon client access to

care.

The contractor also monitors the sponsor's 24 hour availability. Problems encountered are reported to a Monitoring Committee and recommendations for resolution are given to the department.

Evaluation

The P.P. has ben evaluated for cost effectiveness three times by outside contractors. In all of the studies program savings have been significant. The most recent study (for FY 1994) resulted in program savings.

Quality of care has also been studied with P.P. enrollees compared to those in regular Fee For Service. The quality of care has always been found to be a least equivalent to regular fee for service.

Minnesota

Consolidated Chemical Dependency Treatment Fund

PROGRAM NAME: Consolidated Chemical Dependency Treatment Fund	*IMPLEMENTATION DATE:* January 1, 1988
CONTACT: Deb Holtz, 612-296-5867	*EXPIRATION DATE:* February 14, 1996
GEOGRAPHIC AREAS: Statewide	*NUMBER OF ENROLLEES:* any beneficiary requesting CD treatment who meets placement criteria.

FFS (PCCM) OR PRE-PAID OR BOTH: Fee for service

STATUTES UTILIZED: 1915 B(1)

STATUTES WAIVED: 1902(a)(23), 1902(a)(30)

POPULATION CATEGORIES INCLUDED: All fee for service MA recipients in Minnesota who request CD treatment who meet placement criteria.

POPULATION CATEGORIES EXCLUDED: MA recipients enrolled in prepaid health plans.

SERVICES INCLUDED: Outpatient, primary inpatient, extended and transitional rehabilitative chemical dependency.

PCP PROVIDER TYPES: Any licensed provider that is enrolled in the program.

FUTURE PLANS: Continue and re-evaluate in two years.

Minnesota's Consolidated Chemical Dependency Treatment Fund Project

On January 1, 1988, the statewide CCDTF was created by combining existing state appropriations for chemical dependency (CD) rehabilitative services from the following sources; General Assistance (state funds), General Assistance Medical Care (state funds), Medical Assistance or Medicaid (federal and state funds), Regional Treatment Centers (state funds), and other state and federal grants administered by the Department of Human Services. Money from the CCDTF is allocated to Minnesota's county social service agencies and federally recognized Indian reservations (locality) to fund CD rehabilitative services. The locality acts as a case manager in determining the appropriate intensity of CD rehabilitative services needed by a client and restricting the client to receiving those services from a specified provider.

"CD rehabilitative services" means a planned program of care for the treatment of CD or chemical abuse to minimize or prevent further chemical abuse by the person. Medicaid funds can be used under the CCDTF for primary rehabilitative programs, outpatient rehabilitative programs, extended rehabilitative programs and transitional rehabilitative programs within the limitations of amount, duration, and scope defined in the state plan. Coverage does not include payment for room and board except for services provided in an inpatient hospital, nursing facility, or ICF/MR. The CCDTF does not cover CD services mandated and funded under the State's Community Social Service Act (e.g., detoxification, aftercare).

Each locality is responsible for:

1. The assessment and placement of clients residing within the country's jurisdiction who need CD rehabilitative services;

2. The determination of financial eligibility of clients residing within the county's jurisdiction;

3. The establishment of contracts with facilities and /or programs to provide CD rehabilitative services; and

4. The certification of billing invoices for forwarding to the Department of Human Services.

No payment for covered CD rehabilitative services are made outside this system, except through the §1115 Medicaid prepaid demonstration project and §1903(m) prepaid health plans. No federal Medicaid funds are used to pay for services provided to non-Medicaid eligibles.

When completing the assessment and placement components, each locality must follow Minnesota Rule 25, which established statewide criteria for placement in a CD treatment program. The methods of assessment includes a personal interview with the client, collateral contacts and review of relevant records or reports in order to make a finding regarding the extent of the chemical use problems.

Missouri

Jackson County Managed Care Program

PROGRAM NAME: Jackson County Managed Care Program *IMPLEMENTATION DATE:* January 1, 1987

CONTACT: Marineda Jung (314) 751-5178 *EXPIRATION DATE:* June 26, 11997

GEOGRAPHIC AREAS: Jackson County *NUMBER OF ENROLLEES:* 39,406

FFS (PCCM) OR PRE-PAID OR BOTH: both PCCM and Pre-paid

STATUTES UTILIZED: Composition of Enrollment 1903(m)(2)(a)(ii), Disenrollment on Demand 1903(M)(2)(a)(ii), 1915(b)(1), 1915(b)(4)

STATUTES WAIVED: 1902(a)(1), 1902(a)(10), 1902(a)(23)

POPULATION CATEGORIES INCLUDED: AFDC & Related Groups

POPULATION CATEGORIES EXCLUDED: NF, ICF/MR Residents, Medicare Eligibles, Eligible < 6 months, Retro eligible only, other Non-AFDC Categories

SERVICES INCLUDED: All Medicaid covered services except dental, optometry, pharmacy, NF and ICF/MA, Chiropractic, certain rehabilitation services, Family Planning, Emergency, and Expanded EPDST services

PCP PROVIDER TYPES: One Federally Qualified HMO, One State Defined HMO and Two Prepaid Health Plans actually Community Health Centers that qualify as FQHC's. Physicians also are an option to serve as Case Managers.

FUTURE PLANS: Missouri currently has one 1915(b) and one 1115 request pending with HCFA. The Missouri Medicaid Director has indicated that the goal is to provide managed care statewide by the end of 1997.

Missouri's Jackson County Managed Care Program

AFDC and AFDC-related Medicaid recipients in Jackson County (Kansas City, Missouri) may chose to enroll with one Federally Qualified HMO, one State defined HMO, one of two Community Health Centers. Prepaid Health Plans or an individual physician sponsor. The selected plan or physician sponsor provides or prior authorizes all primary care services and all speciality services. The HMO, PHP, or physician sponsor is responsible for monitoring health care and utilization of non-emergency services. Neither emergency or family planning services are restricted under the waiver.

Mississippi

Health MACS

PROGRAM NAME: Health MACS *IMPLEMENTATION DATE:* October 1, 1993

CONTACT: Bo Bowen (601) 359-6050 *EXPIRATION DATE:* September 30, 1995

GEOGRAPHIC AREAS: Washington, Warren, Claiborne, Jefferson, Lawrence, Jefferson Davis and Covington Counties *NUMBER OF ENROLLEES:* 31,989

FFS (PCCM) OR PRE-PAID OR BOTH: FFS (PCCM)

STATUTES UTILIZED: 1915(b)(1)

STATUTES WAIVED: 1902(a)(1), 1902(a)(10)(B), 1902(a)(23)

POPULATION CATEGORIES INCLUDED: AFDC/AFDC-related

POPULATION CATEGORIES EXCLUDED: all eligibility categories other than AFDC/AFDC-related

SERVICES INCLUDED: all services covered by the Title XIX State Plan except: dental, psychiatry, ophthalmology, optometry, eyeglasses, podiatry, nursing facility, ICF-MR, non-emergency and ambulance/wheelchair van services

PCP PROVIDER TYPES: Family practitioners, general practitioners, pediatricians, obstetricians, gynecologists, internists, physician group practices, federally qualified health centers, rural health clinics, State Department of Health clinics, and nurse practitioners: pediatric, adult, family OB-GYN, and certified nurse midwives

FUTURE PLANS: renewal for October 1, 1995 to add 8 additional counties

The Mississippi HealthMACS Program

Health through Medicaid Managed Access to Care and Services (HealthMACS) is a primary care case management program for certain Medicaid-eligibles in certain counties. Each Medicaid-eligible is enrolled with a primary care provider (PCP) for management of health care needs. The *objectives* of HealthMACS are:

To improve access to quality care
To assure appropriate utilization of services
To enhance the physician/patient relationship
To achieve cost efficiency in health care delivery

Primary Care Providers

Physicians	Clinics/Health Centers	Certified Nurse Practitioners
Family Practitioners	Physician Group Practices	Pediatric Nurse Practitioners
General Practitioners	FQHCs	Adult Nurse Practitioners
Pediatricians	Rural Health Clinics	Family Nurse Practitioners
Obstetricians	Health Department Clinics	Certified Nurse Midwives
Gynecologists	OB-GYN Nurse Practitioners	Internists

Any individual or group listed above, who is currently a Medicaid provider in good standing, may become a PCP in the HealthMACS program. Enrollment applications and provider agreements may be obtained from the Managed Care Unit at EDS by calling the HealthMACS Enrollment Line At 1-800-884-3240.

PCPs may have a maximum of 1500 HealthMACS enrollees per physician or 500 per nurse practitioner. The PCP is paid a $3.00 per month case management fee for each HealthMACS enrollee.

HealthMACS *advantages* for PCPs include:

Allows physician to develop a physician/patient relationship
Provides for primary physician control of services received by patients
Maintains the fee-for-service payment methodology
Includes a monthly case management fee

General *responsibilities* of PCPs are:

Foster an ongoing physician/patient relationship
Provide primary care services, including prevention, health maintenance/treatment of illness/injury
Coordinate/arrange access to needed specialty and other health services, Provide or arrange for after-hours coverage

HealthMACS Population

Medicaid-eligibles who receive Aid to Families with Dependent Children (AFDC) and AFDC-related Medicaid-eligibles in certain counties are required to participate in HealthMACS. Staff at the Department of Human Services inform these Medicaid-eligibles about the HealthMACS program and tell them to call the HealthMACS Enrollment Line to request the assignment of a PCP of their choice. For those who do not call the Enrollment Line, a PCP is assigned based on claims history or zip code. Those who are assigned to a PCP in one of these ways are notified by letter and given the Enrollment Line number to call if they wish to request to change to another PCP.

HealthMACS *advantages for enrollees* include:

Assures adequate access to quality health care services
Enhances or establishes physician/patient relationships
Provides continuity of care
Encourages use of preventive and maintenance health services

Client Services/Education Outreach

Recipient education is an essential component of the HealthMACS program. To enhance this aspect of the program, recipient representatives, persons who live in the communities in which the enrollees live, are being hired to work with HealthMACS enrollees. The recipient representatives will be available by telephone (Client Services Telephone Representatives) or in the field (Field Representatives) to both the recipient and the PCP. Recipient representatives will provide the HealthMACS enrollees with information about community outreach programs/services as well as basic health care information. Recipient representatives will be available to the PCP to assist in counseling recipients about missed appointments, appropriate use of the emergency rooms, and other health matters as requested by the PCP.

HealthMACS Hotline: 1-800-627-8488; HealthMACS Enrollment Line: 1-800-884-324
Division of Medicaid: 1-800-421-2408; 601-359-6050.

Montana

Passport to Health

PROGRAM NAME: Passport to Health

ORIGINAL IMPLEMENTATION DATE: January 1, 1993

CONTACT: Sharon Donovan
(406) 444-4148

EXPIRATION DATE: July 31, 1995

GEOGRAPHIC AREAS:
all but 5 counties

NUMBER OF ENROLLEES: 49,500

FFS (PCCM) OR PRE-PAID OR BOTH: FFS (PCCM)

STATUTES UTILIZED: 1915(b)(1)

STATUTES WAIVED: 1902(a)(23), 1902(a)(10), 1902(a)(1)

POPULATION CATEGORIES INCLUDED: AFDC/AFDC-related; SSI/SSI-related

POPULATION CATEGORIES EXCLUDED: medically needy; NF/ICF-MR; HMO enrollees; foster care

SERVICES INCLUDED: inpatient hosp., outpt. Hosp., physician, FQHC/RHC, EPSDT, inpatient psychiatric care, nurse specialists

PCP PROVIDER TYPES: physician, FQHC , RHC, IHS Clinics, Mid-levels

FUTURE PLANS: implement statewide

Montana Passport to Health

Passport to Health is a primary care case management program involving AFDC, AFDC-related, and SSI populations in nearly 40 counties across Montana. As of December, 1994, of the 65,450 individuals targeted for enrollment in Passport, 52,532 people were actively enrolled in the program.

The waiver program provides or authorizes a comprehensive set of State plan services. Specialty physicians and mid-level practitioners as well as FQHCs, rural health clinics, Indian Health Service (IHS) clinics, and other clinics meeting Passport criteria participate as PCPs. Nearly 75% of all physicians and FQHCs eligible to participate in Passport are now enrolled in the program.

The State will be arranging for clinical quality improvement studies in the areas of childhood immunizations, prenatal care, and pediatric asthma. Montana intends to convene a workgroup consisting of representatives from the State, HMOs, providers and consumer advocates to specifically define the clinical studies undertaken.

North Carolina

Carolina ACCESS

PROGRAM NAME:
Carolina ACCESS

ORIGINAL IMPLEMENTATION DATE:
April 1, 1991

CONTACT: Sherry Hay
ACCESS Supervisor (919) 715-5417

EXPIRATION DATE:
June 30, 1997

GEOGRAPHIC AREAS: Beaufort, Buncombe, Burke, Caldwell, Caswell, Chatham, Cleveland, Davidson, Durham, Edgecombe, Forsyth, Greene, Harnett, Haywood, Henderson, Jackson, Lee, Lenoir, Madison, Moore, Nash, Onslow, Orange, Person, Pitt, Scotland, Surry, Wake, Wayne

NUMBER OF ENROLLEES: 188,553

FFS (PCCM) OR PRE-PAID OR BOTH: FFS (PCCM)

STATUTES UTILIZED: 1915(b)

STATUTES WAIVED: 1902(a)(1), 1902(a)(10)(B), 1902(a)(23)

POPULATION CATEGORIES INCLUDED: AAF, MAF, MIC, MAD, MAB, MAA, SSI (Medicare/Medicaid recipients, Medicare/SSI recipients have the option to enroll with the waiver program)

POPULATION CATEGORIES EXCLUDED: MPW, MQB, MRF, MSB, IAS, HSF, RRF, SAA, SAD, and any recipient in: deductible status; retroactive coverage; an intermediate care or skilled nursing facility; an intermediate care facility for the mentally retarded; a domiciliary care facility; or a psychiatric hospital

SERVICES INCLUDED: All Medicaid covered services are included under the waiver, though some covered services do not require primary care provider authorization to receive reimbursement.

PCP PROVIDER TYPES: Pediatrics, Family Practice, Internal Medicine, Multi specialty, Hospital Outpatient Clinics, OB/GYN, Health Departments, Rural Health Centers, FQHCs

FUTURE PLANS: Our immediate plans include extensive evaluation of policies and procedures in existing Carolina ACCESS counties, while continuing expansion to other counties as staff availability will allow. At the same time, some staff efforts will focus on evaluating or developing some additional capitation models. It is likely some Carolina ACCESS counties will make a transition into capitation (partial and/or full) in the future, along with other counties not currently affected by the wavier.

North Carolina ACCESS

Carolina ACCESS (CA) was implemented as a demonstration project in April 1991, through the cooperative efforts of the North Carolina Department of Human Resources, Division of Medical Assistance (DMA), and the North Carolina Foundation for Alternative Health Programs. Partial funding was provided through a grant from the Kate B. Reynolds Health Care Trust. The pilot phase was completed in January 1992. The program anticipates operation in a total of 38 counties by November 1995. Carolina ACCESS currently operated as a part of the Managed Care Unit of DMA.

The program objective is to provide a more efficient and effective health care system for Medicaid recipients. The goals of the program include:

- Establishing a continuous and comprehensive patient/provider relationship
- Optimizing state and county investments for health care services
- Reducing inappropriate use of emergency department
- Promoting the preventive aspects of health care
- Improving access to primary care for Medicaid recipients

To achieve these goals, each Carolina ACCESS county has a Carolina ACCESS Plan Representative who is employed by the county to administer the program on a local level. This individual remains accessible to DSS employees, Medicaid recipients, the provider community, and any other interested party and plays a key role in program education in each of these areas.

In July 1993, an Emergency Department (ED) Policy was implemented to reduce inappropriate use of the ED and redirect patients to their primary care provider (PCP) for

non-emergent care. The policy lists "true emergencies" by ICD-9 codes and allows treatment of true emergencies 24 hours a day, seven days a week. Non-emergent conditions may be triaged in the ED at any time; however, treatment of a non-emergent condition in the ED will not be reimbursed without authorization from the PCP of the Raleigh Carolina ACCESS staff.

PCPs receive a management fee of $3.00 per member per month (PMPM) for the first 250 members enrolled with their practice and $2.50 PMPM for each person thereafter. In addition to meeting Medicaid provider participation requirements, providers must meet the following criteria to serve as a CA PCP:

- Be open a minimum of 30 hours per week
- Provide 24 hour coverage (must not automatically refer to ED)
- Provide preventive and ancillary services as specified by the CA Physician Advisory Committee. For children this includes: Health Check, DPT, Polio vaccine, MMR, HIB, Hepatitis B, Urinalysis, Hematocrit. For adults this includes: Adult Health Screening, Pap Smear, Hematocrit, Pneumovax, Flu Vaccine, DT.
- Be willing to accept a minimum of 50 CA members

North Dakota

North Dakota Access and Care (PCCM)

PROGRAM NAME: North Dakota Access and Care (PCCM)

ORIGINAL IMPLEMENTATION DATE: January 1, 1194

CONTACT: Darlene LeNoue
701-328-4577

EXPIRATION DATE: December 31, 1995

GEOGRAPHIC AREAS: Statewide

NUMBER OF ENROLLEES: 31,OOO

FFS (PCCM) OR PRE-PAID OR BOTH: FFS

STATUTES UTILIZED: 1915(b)(1)

STATUTES WAIVED: 1902(a)(23); 1902(a)(10)

POPULATION CATEGORIES INCLUDED: AFDC, Poverty Level Families, Medically Needy

POPULATION CATEGORIES EXCLUDED: SSI, Medicare, NF, ICF/MR

SERVICES INCLUDED: Inpatient Hospital, Outpatient Hospital, FQHC, RHC, Lab/X-ray, Physician, Private duty Nursing, Physical Therapy, Occupational Therapy, Speech/Hearing, Home Health DME, Hospice

PCP PROVIDER TYPES: Physicians, RHCs, FQHCs, Indian Health Clinics

FUTURE PLANS: Incorporate HMOs into the waiver

North Dakota Access and Care Program

The goal of NODAC is to provide primary care case management for AFDC and AFDC-related individuals throughout the State in order to contain costs, ensure appropriate utilization, enhance quality and continuity of care, and ensure access. This is achieved through the use of primary care physicians (PCPs). The PCP is responsible for providing or arranging for 24-hour, 7-day per week physician availability to enrolled recipients.

NODAC retains the fee-for-service principle. Certain services are excluded from the preauthorization requirement and will be paid on a fee-for-service basis without restriction. PCPs in NODAC can be physicians, rural health clinics, federally qualified health clinics, and the Indian Health Services. Although the State set the maximum physician to client ratio of 1500:1, ratios for the program's 32,000 enrollees fall far short of this limit.

New Mexico

Primary Care Network

PROGRAM NAME: Primary Care Network	*ORIGINAL IMPLEMENTATION DATE:* March 1, 1991
CONTACT: Carolyn Banks (505) 827-3110	*EXPIRATION DATE:* July 31, 1995 (renew)
GEOGRAPHIC AREAS: Statewide	*NUMBER OF ENROLLEES:* 125,143

FFS (PCCM) PREPAID OR BOTH: PCCM

STATUTES UTILIZED: 1915(b)(1)

STATUTES WAIVED: 1902(a)(1), 1902(a)(23) of the Act

POPULATION CATEGORIES INCLUDED: All Title XIX eligibles

POPULATION CATEGORIES EXCLUDED: Medicare Coverage, reside in a N/F or ICF/MR, enrolled in another M/C program, have an eligible period that is only retroactive, eligible for foster care children, exsurption leased on lack of providers in area, or special medical needs, and home and community based waivers

SERVICES INCLUDED: Inpatient hospital, outpatient hospital, rural health clinic, laboratory, x-ray, EPSDT physician, FQHC, pharmacy

PCP PROVIDER TYPES: General practitioners, family practitioners, internists, pediatricians, OB-Gynecologists, physicians clinics, rural health clinics.

FUTURE PLANS: 1915(b) waiver for physical health (late/early 1995/1996)
1915(b) waiver for mental health (late/early 1996/1997)
Potential waiver for long term care (late /early 1997/1998)

New Mexico Primary Care Physician Program

Under the waiver, Medicaid beneficiaries are allowed to select a primary care provider (PCP) who furnishes, through an ongoing patient/provider relationship, primary care services and referrals for all necessary, specialty services. The PCP is responsible for monitoring the health care and utilization of non-emergency services. Emergency and family planning services are not restricted under the waiver.

The PCP will assist the PCN members' gain access to the health care system and will monitor the members' condition, health care needs, and service delivery on an ongoing basis. The PCP will be responsible for coordinated and monitoring all primary care and other medical and rehabilitation services on behalf of PCN members enrolled in the waiver program.

PCN members enrolled can only receive services included under the waiver either from the chosen or assigned PCP or from another Medicaid provider to whom the participant was referred by the PCP. The members' health care delivery will be managed by the PCP. The intent of the waiver is to enhance existing provider-patient relationships and to establish a relationship where there has been none. In meeting this intent, the waiver will enhance continuity of care and efficient and effective service delivery.

Services not covered under the waiver (i.e., services which do not require a referral) are obtained in the same manner as under the regular Medicaid program. Medicaid beneficiaries are informed of the services not covered under the waiver and the process for obtaining such services.

The PCN member has the right to choose a Federally Qualified Health Center (FQHC) as a PCP, or choose a PCP that has arrangements with an FQHC. If the PCN member elects not to select the PCP that would give him or her access to FQHC services, no FQHC services are required to be furnished to the member while the member is enrolled with the PCP he or she selected. In any event, since reasonable access to FQHC services is available under the waiver program, FQHC services outside the program are not available.

New York

Southwest Brooklyn Case Management Program

PROGRAM NAME: Southwest Brooklyn Case Management Program

ORIGINAL IMPLEMENTATION DATE: 10/1/1992 through 9/30/1994

CONTACT: Ellen Anderson
NYS - Dept. Of Health
518-474-5737

EXPIRATION DATE: 9/24/1997

NUMBER OF ENROLLEES: 47,715

GEOGRAPHIC AREAS: Brooklyn, NY

FFS (PCCM) OR PRE-PAID OR BOTH: Pre-paid

STATUTES UTILIZED: 1915(b)(1) and 1915(b)(4)

STATUTES WAIVED: 1902(a)(1) and 1902(a)(23)

POPULATION CATEGORIES INCLUDED: AFDC

POPULATION CATEGORIES EXCLUDED: All other than AFDC

SERVICES INCLUDED: Comprehensive

PCP PROVIDER TYPES: IPA/Group Model/Staff Model

New York Southwest Brooklyn Primary Case Management Program

New York received approval to implement this mandatory primary care case management program for the period 10/1/92 through 9/30/94. The program requires that AFDC beneficiaries in a ten zip code area in Southwest Brooklyn select one of nine participating managed care entities (HMOs/PHSPs) from which they will receive coordinated comprehensive medical services.

New York

Broome County Case Management PCCM Program

PROGRAM NAME: Broome County Case Management PCCM Program

ORIGINAL IMPLEMENTATION DATE: October 1, 1991

CONTACT: Ellen Anderson
NYS-Dept. Of Health
518-474-5737

EXPIRATION DATE: March 31, 1996

NUMBER OF ENROLLEES: 3,845

GEOGRAPHIC AREAS: Broome County, NY

FFS (PCCM) OR PRE-PAID OR BOTH: Enhanced FFS

STATUTES UTILIZED: 1915(b)(1)

STATUTES WAIVED: 1902(a)(1), 1902(a)(10), and 1902(a)(23)

POPULATION CATEGORIES INCLUDED: AFDC, AFDC related, SSI, SSI-related

POPULATION CATEGORIES EXCLUDED: none

SERVICES INCLUDED: All Medicaid covered services are included under the waiver with the exception of transportation and nursing home and ICF/MR services. These are available through regular Medicaid

PCP PROVIDER TYPES: IPA and Group model

New York Broome County Case Management PCCM Program

This program provides primary care services by multiple physicians in both group and private practice. Primary care physicians are responsible for care plans in addition to managing and acting as gatekeepers for a defined set of services. A separate case management organization is responsible for monitoring physician practice patterns and costs, performing client education and follow-up, and assisting in the coordination of a broad range of services.

New York

Comprehensive Partial Capitation Clinic Program (CPCCP)

PROGRAM NAME: Comprehensive Partial Capitation Clinic Program (CPCCP)

ORIGINAL IMPLEMENTATION DATE: 2/24/1995

CONTACT: Ellen Anderson
NYS-Dept. Of Health
518-474-5737

EXPIRATION DATE: 02/23/1997

NUMBER OF ENROLLEES: 2,000

GEOGRAPHIC AREAS: Statewide

FFS (PCCM) OR PRE-PAID OR BOTH: Pre-Paid

STATUTES UTILIZED: 1915(b)(1)

STATUTES WAIVED: 1902(a)(1), 1902(a)(10)(B), 1902(a)(23), and 1902(a)(30)(A)

POPULATION CATEGORIES INCLUDED: All categories except SSI

POPULATION CATEGORIES EXCLUDED: SSI

SERVICES INCLUDED: Primary Care Services Including Physician Services, Lab and X-Ray

PCP PROVIDER TYPE: Group model

New York Comprehensive Partial Capitation Clinic Program

This State-wide waiver was developed to allow hospital-based outpatient departments and diagnostic and treatment centers to provide coordinated health care services to Medicaid beneficiaries throughout the state. The waiver permits the State to share savings with the partially capitated providers. There

are currently two sites located in New York City that participate in this waiver.

Ohio

Montgomery County Health Alternative Program

PROGRAM NAME:
Montgomery County Health Alternative Program 1915(b)

ORIGINAL IMPLEMENTATION DATE:
May 19, 1989

CONTACT: Cynthia Burnell
(614) 466-4693

EXPIRATION DATE:
January 27, 1997

GEOGRAPHIC AREAS:
Montgomery County

NUMBER OF ENROLLEES: 35,189

FFS (PCCM) OR PRE-PAID OR BOTH: Pre-Paid

STATUTES UTILIZED: 1915(b)

STATUTES WAIVED: 1902(a)(I), 1902(a)(10), 1902(a)(23), 1902(a)(30)

POPULATION CATEGORIES INCLUDED: ADC and Healthy Start

POPULATION CATEGORIES EXCLUDED: All others

SERVICES INCLUDED: Inpatient and Outpatient Hospital, Laboratory, X-Ray, EPSDT, Family Planning, Physician, Home Health, FQHC Services, Dental, Psychiatric, Pharmacy, other.

PCP PROVIDER TYPES: Family Physician, General Practice, Internal Medicine, OB-GYN, Pediatrician.

FUTURE PLANS: Ohio received a statewide 1115 waiver in January 1995

Ohio Montgomery County Health Alternative Plan

The Montgomery County Health Alternative Plan (MCHAP) is a mandatory enrollment managed care plan for the AFDC and Healthy Start population in the Dayton, Ohio area. This program, formerly known as the Dayton Area Health Plan, has been in existence since 1989 and has a 1995 total enrollment of 35, 200 recipients.

Under MCHAP, the State has risk-comprehensive contracts with three HMOs, Health Plan Network - Dayton Area Health Plan (DAHP), Daymed HMO, and Health Power HMO. Health Plan Network - DAHP operates under a legislative waiver of the 75/25 enrollment mix requirement. The HMOs offer the full range of Medicaid-covered services, with the exception of non-rehabilitative long-term care. The HMOs are required to develop and participate in joint advisory councils consisting of provider, consumer, and community members. These councils offer a local forum for the identification of issues and development of resolutions related to mandatory enrollment

Enrollment in MCHAP is handled by an enrollment broker, Patterson Consulting. Medicaid applicants, on completion of their interview at the county human services office, are referred to an Enrollment Information Center located in the same building. The enrollment broker staff show the client a video that outlines HMO enrollment options and explains enrollment/disenrollment, recipient responsibilities, the complaint process, use of medical services, and other relevant information. Clients are also provided with member handbooks and enrollment forms. Individuals who do not subsequently make an HMO selection are issued follow-up letters and, if no response is received, are auto assigned on a rotating basis to an HMO.

Ohio's managed care quality monitoring program for MCHAP includes annual external quality review evaluations, quarterly reviews of HMO operations and service provision, and quarterly reviews of utilization data. As one of the states participating in the Quality Assurance Reform Initiative (QARI) demonstration, Ohio implemented and has continued to apply the concepts of an integrated Health Care Quality Improvement System (HCQIS) in its managed care programs, including MCHAP.

Ohio

Hamilton County Health Alternative Plan

PROGRAM NAME: Hamilton County Health Alternative Plan 1915(b)	*ORIGINAL IMPLEMENTATION DATE:* April 1995
CONTACT: Cynthia Burnell (614) 466-4693	*EXPIRATION DATE:* February 1997
GEOGRAPHIC AREAS: Hamilton County	*NUMBER OF ENROLLEES:* 36,750

FFS (PCCM) OR PRE-PAID OR BOTH: Pre-Paid

STATUTES UTILIZED: Ohio Revised Code 5111.17, 1915(b)

STATUTES WAIVED: 1902(a)(1), 1902(a)(10), 1902(a)(23), 1902(a)(30)

POPULATION CATEGORIES INCLUDED: ADC and Healthy Start

POPULATION CATEGORIES EXCLUDED: All others

SERVICES INCLUDED: Inpatient and Outpatient Hospital, Laboratory, X-ray, EPSDT, Family Planning, Physician, Home Health,, FQHC Services, Dental, Psychiatric, Pharmacy and other.

PCP PROVIDER TYPES: Family Physician, General Practice, Internal Medicine, OB/GYN and Pediatrician.

FUTURE PLANS: Ohio received a statewide 1115 waiver in January 1995.

Ohio Hamilton County Health Alternative Plan

The Hamilton County Health Alternative Plan (HCHAP) is a mandatory enrollment managed care plan for the AFDC and Healthy Start population in the Cincinnati, Ohio area. This program was implemented April 1995 and has a 1995 enrollment of 36,750 recipients.

Under HCHAP, the State has risk-comprehensive contracts with six HMOs, DAHP/Cincinnati Health Plan, Daymed HMO, Health Power of Cincinnati, Choice Care, HMO Health Ohio, and United Health Care. The HMOs offer the full range of Medicaid-covered services, with the exception of non-rehabilitative long-term care.

The HMOs are required to develop and participate in joint advisory councils consisting of provider, consumer, and community members. These councils offer a local forum for the identification of issues and development of resolutions related to mandatory enrollment

Enrollment in HCHAP is handled by an enrollment broker. Medicaid applicants, on completion of their interview at the county human services office, are referred to an Enrollment Information Center located in the same building. The enrollment broker staff show the client a video that outlines HMO enrollment options and explains enrollment/disenrollment, recipient responsibilities, the complaint process, use of medical services, and other relevant information. Clients are also provided with member handbooks and enrollment forms. Individuals who do not subsequently make an HMO selection are issued follow-up letters and, if no response is received, are auto assigned on a rotating basis to an HMO.

Ohio's managed care quality monitoring program for HCHAP includes annual external quality review evaluations, quarterly reviews of HMO operations and service provision, and quarterly reviews of utilization data. As one of the states participating in the Quality Assurance Reform Initiative (QARI) demonstration, Ohio implemented and has continued to apply the concepts of an integrated Health Care Quality Improvement System (HCQIS) in its managed care programs, including HCHAP.

Oregon

Medicaid Medical Transportation Program

PROGRAM NAME: Medicaid
Medical Transportation Program

ORIGINAL IMPLEMENTATION DATE:
September 1, 1994

CONTACT: Joan Frye
Program Manager, Program and
Office of Medical Assistance Programs
(503) 945-6493

EXPIRATION DATE: August 31, 1996

NUMBER OF TRI-COUNTY ELIGIBLES: 143,748

GEOGRAPHIC AREAS: Multnomah,Washington and Clackamas (Tri-County)

FFS (PCCM) OR PRE-PAID OR BOTH: Flat Fee Per Ride

STATUTES UTILIZED: 1915(b)(4)

STATUTES WAIVED: 1902(a)(1), 1902(a)(23), 1902(a)(32)

POPULATION CATEGORIES INCLUDED: All Oregon Title XIX Eligibles

POPULATION CATEGORIES EXCLUDED: Qualified Medicare Beneficiaries (i.e. those QMBs who have only cost-sharing on Medicare items/services and who do not also qualify for Medicaid items/services).

SERVICES INCLUDED: Non-emergency medical transportation to medical services

PCP PROVIDER TYPES: Medical Transportation Broker

FUTURE PLANS: Oregon may consider expansion of the Brokerage to other areas of the state where cost effectiveness would be demonstrated

Oregon Non-Emergency Transportation Program

- Brokerage implemented 9-1-94 in Washington, Clackamas and Multnomah Counties
- Number of eligibles - 143,748 (as of 6-30-95)
- Number of rides June '95 - 64,586
- Approximately 70% now using public transportation
- Broker does only non-emergency medical transportation except for:
  - non-emergency ambulance (Branches still do)
  - client reimbursed mileage (Branches still do)
- OMAP downloads eligibility data daily but does not send eligibility records for clients not eligible for non-emergency medical transportation, ie. QMB's illegal aliens, etc.
- Broker downloads ride manifests to subcontractors on-line. Brokers system has capability of viewing sub-contractors as they dial in and pick up their ride manifests.
- Broker can see on-line number of calls in process, number of calls in queue and length of time client on hold. Information is stored for reporting purposes.
- Broker determines eligibility of client, screens for level of ride needed and dispatches ride.
- Subcontractors bill Broker - Broker bills OMAP on a flat cost-per-ride. Rate effective September 1, 1994 was $7.98 per ride. Effective March 1, 1995 the rate per ride has been reduced to $6.05 per ride.
- Tri-County Work Group acts as oversight committee. Meets monthly to discuss access issues, client utilization, complaints, etc.
- Written denial notices are sent to clients in appropriate language.
- Broker sends monthly status updates and statistical reports showing utilization, dollars, etc. Reports are distributed to all Division Administrators, Tri-County District Mangers, etc.

Pennsylvania

HealthPASS

PROGRAM NAME: HealthPASS

ORIGINAL IMPLEMENTATION DATE: March 3, 1986

CONTACT: Thomas M. Orlowaki
(717) 772-6292

EXPIRATION DATE: December 31, 1996

GEOGRAPHIC AREAS: Five districts in Philadelphia County including Delancey, Federal, Snyder, Vine, and West

NUMBER OF ENROLLEES: 70,000

FFS (PCCM) OR PRE-PAID OR BOTH: Pre-paid capitated

STATUTES UTILIZED: 1915(b)(1) and 1915(b)(3)

STATUTES WAIVED: 1902(a)(1); 1902(a)(10); 102(a)(23); & 1902(m)(30)

POPULATION CATEGORIES INCLUDED: AFDC; GA; SSI; Healthy Beginnings; & Healthy Horizons (over 65)

POPULATION CATEGORIES EXCLUDED: Presumptive eligibles; monthly spend downs; pre-release grants; one time issuances; residents of nursing homes; Medicare buy-in only; state blind pension; retroactive eligible only; recipients admitted to state mental retardation center, state restoration center, long-term acute psychiatric facility, and residential treatment facility.

SERVICES INCLUDED: All Medicaid services currently provided by FFS except; nursing home care, psychiatric clinic, partial psychiatric hospitalization, methadone maintenance clinic, and drug and alcohol services which are provided through FFS, extended acute psychiatric hospital, general transportation services, private ICF/MR, case management (MH/MR), early intervention, education rehabilitation service, family-based therapy, crisis intervention, and funeral director.

PCP PROVIDER TYPES: Physician, hospital outpatient clinic, federally qualified health center, and school-based health center.

FUTURE PLANS: To sole source a contract for 1996 with Healthcare Maintenance Alternatives, Inc., to continue providing services until the program can be folded into the proposed HealthChoices Program.

Pennsylvania HealthPASS Program

In March 1986, Pennsylvania's Health Insuring Organization (HIO) known as HealthPASS began serving clients in South and West Philadelphia. An HIO is an entity that pays for medical services provided to recipients in exchange for a premium or subscription charged paid by the agency and assures an underwriting risk. Unlike a Health Maintenance Organization (HMO), it does not provide health services directly, but contracts with health care providers.

Today, HealthPASS provide acute and preventive care for approximately 70,000 recipients. This includes, but is not limited to

- Physician services;
- Impatient and hospice care;
- Emergency services;
- Home health care;
- Family planning;
- Maternal and child care;
- Prescription drugs;
- Medical equipment;
- Dental and eye care;
- Non-residential substance abuse treatment;
- Podiatric; and
- Chiropractic services

Currently, HealthPASS is not responsible for long term care, psychiatric clinic, partial psychiatric hospitalization, methadone maintenance clinic, and drug and alcohol clinic services. These services are covered under the regular Medicaid Fee-For-Service Program.

The cornerstone of the HealthPASS Program is its case management system. Every HealthPASS enrollee has a primary care physician. (PCP) responsible for coordinating their medical care, providing preventive care, referring them to specialists when necessary, and following their progress when an illness requires hospital treatment.

To ensure easy access to care, physicians must be available for at least 20 regular office hours per week and must maintain 24-hour phone coverage. In case of emergency, recipients have immediate access to hospital emergency room services.

HealthPASS operates a toll-free telephone hotline 24 hours a day, seven days a week. Recipients may use the hotline to ask questions regarding HealthPASS policies, transfer to a new doctor, or register

complaints. All potential quality of care complaints are forwarded to the Quality Assurance Department for review and follow-up. Interpreters are available for recipients with a language barrier.

The HealthPASS Program is dedicated to an energetic health education and outreach program. These special initiatives are member-focused and sensitive to the special needs of the population served and include:

- The Unborn/Newborn Initiative which among other things offers assistance in identifying providers and resources such as WIC and EPDST.

- The Lay Home Visiting Program which provides both pre and postnatal home visits and the home visitors provide outreach education, support, and linkage to existing services.

The HealthPASS Quality Assurance System promotes the delivery of quality and cost effective health care to all enrollees. Under a plan approved by the State, the HealthPASS contractor operates an extensive internal quality assurance program to ensure the recipients receive the health care they needed and that providers meet their contractual obligations under HealthPASS.

The State continuously monitors the HealthPASS Program through on-site visits and other procedures to make sure the quality assurance program is being thoroughly carried out.

An independent medical audit contractor has monitoring and evaluation responsibilities to determine if appropriate medical care is provided, medical records are up-to-date, and participating health care providers are properly credentialed.

An independent evaluation of the HealthPASS Program in 1991 concluded that the HealthPASS Program has extensive quality assurance mechanisms in place and operating.

The study also found that mortality rates, a fundamental indicator of quality, were lower under HealthPASS than under the Medicaid Fee-For-Service system.

Studies show that the HealthPASS Program has saved the Commonwealth money as opposed to the same care being provided through the Medicaid Fee-For-Service Program.

Pennsylvania

Family Care Network

PROGRAM NAME: Family Care Network

ORIGINAL IMPLEMENTATION DATE: February 1, 1994

CONTACT: Donald Yearsley
(717) 772-6341

EXPIRATION DATE: July 31, 1996 (Extended)

GEOGRAPHIC AREAS:
Every county except for Berks, Bucks, Chester, Delaware, Montgomery and Philadelphia

NUMBER OF ENROLLEES:
Approximately 326,000 children & Adolescents

FFS (PCCM) OR PRE-PAID OR BOTH: FFS (PCCM)

STATUTES UTILIZED: 1915(b)(1)

STATUTES WAIVED: 1902(a)(1); 1902(a)(10)(B); and 1902(a)(23)

POPULATION CATEGORIES INCLUDED: AFDC and AFDC-related Medicaid Clients under 21

POPULATION CATEGORIES EXCLUDED: Medicaid clients over 21 years old; clients enrolled in an HMO, HIO; in foster care placement or subsidized adoption; or eligible for limited short-term coverage

SERVICES INCLUDED: All Medicaid services provided by FFP, including EPSDT

PCP PROVIDER TYPES: Physician, hospital outpatient clinic, independent medical clinic, rural health clinic, or federally qualified health center

FUTURE PLANS: To implement FCN in the remaining counties, except those listed above.

Pennsylvania Family Care Network

The Family Care Network (FCN) is a mandatory primary care case management program plan for Medicaid recipients under the age of 21 to be operational in 60 counties. In October 1993, HCFA approved the Department's request for a 1915(b) waiver to implement the FCN. The FCN links recipients with doctors, health care centers, or clinics that participate in the Medical Assistance Program and are enrolled in the FCN. The providers of the FCN act as primary care case managers for recipients under age 21 and are paid a monthly case management fee of $3.00 for each recipient assigned to them. The FCN is not a risk-based capitated program. The monthly case management fees are paid through the Department's fee-for-service system.

In February 1994, the FCN was implemented in York County which served as the pilot county for the FCN. To date, 57 counties have been phased into the FCN with an approximate enrollment of 326,000 children and adolescents under age 21.

Medical assistance benefits for most recipients enrolled in the FCN did not change. However, there were some changes in the way these recipients received their medical benefits.

The Department selected Automated Health Systems Incorporated (AHSI) to administer the FCN. AHSI is the contractor that also administers the Department's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. The duties for which AHSI are responsible to provide to recipients in the FCN, under the terms of their contract with the Department, include but are not limited to the following:

- Recruit, enroll, and provide technical support for FCN providers;
- Assist recipients in selecting a primary care case manager;
- Process changes in provider/recipient assignment;
- Compile and submit date to the Department in order to pay FCN providers monthly case management fees;
- Notify providers of the recipients enrolled with them;
- Notify recipients of their enrollment with the provider; and
- Issue membership cards to recipients enrolled in the FCN.

Primary care case managers of the FCN provider most outpatient medical assistance services such as immunizations; EPSDT examinations; and illnesses not requiring emergency or a specialist referral. The primary care case manager has the authority to refer a recipient to a specialist or to other community services when the situation warrants.

In turn, the recipient may self-refer to some services such as emergency or ambulance services;

prescription drugs; dental services; vision examinations and eyeglasses; and mental health and drug and alcohol services. If the recipient obtains services from another provider, other than the FCN provider they enrolled with, the Medical Assistance Program may not pay for these services.

There are exclusions to enrollment in the FCN by recipients. Some of these are:

- Receipt of services in Berks, Bucks, Chester, Delaware, Lancaster, Montgomery, or Philadelphia Counties;
- Reside in a nursing home or other residential treatment facility;
- Children in foster care or subsidized adoption;
- Choose to enroll with a medical assistance or private HMO;
- Receipt of a state blind pension; and
- Eligible for medical assistance benefits for less than 90 days.

Pennsylvania

Lancaster Community Health Plan

PROGRAM NAME: Lancaster Community Health Plan	*ORIGINAL IMPLEMENTATION DATE:* May 1, 1995
CONTACT: Donald Yearsley (717) 772-6341	*EXPIRATION DATE:* April 30, 1997
GEOGRAPHIC AREAS: Lancaster County	*NUMBER OF ENROLLEES:* 4,000

FFS (PCCM) OR PRE-PAID OR BOTH: Capitated - FFS

STATUTES UTILIZED: 1915(b)

STATUTES WAIVED: 1902(m)(1); 192(m)(10)(B); and 1902(a)(23)

POPULATION CATEGORIES INCLUDED: AFDC; AFDC-related; SSI; and SSI-related

POPULATION CATEGORIES EXCLUDED: Medicare recipients, residents of nursing homes; recipients who travel more than 75 miles or 90 minutes to obtain services; eligibility of less than 3 months; and retroactive eligibility only, or enrolled in another managed care program

SERVICES INCLUDED: All Medicaid-covered services

PCP PROVIDER TYPES: Physician, hospital outpatient clinic, independent medical clinic, or federally qualified health center.

FUTURE PLANS: Continue to enroll clients at a rate of 2,000 a month. When fully implemented, it is expected that 20,000 clients will be receiving services through LCHP.

Pennsylvania Lancaster Community Health Plan

In February 1994, HCFA approved the Department's request for a 1915(b) waiver to implement a primary care case management program for all eligible medical assistance of all ages exclusively in Lancaster County. This program is called the Lancaster Community Health Plan (LCHP). Since May 1, 1995, the implementation date for the LCHP, approximately 2,000 recipients have been enrolled. Once fully implemented , it is expected that approximately 20,000 recipients will be receiving their medical services through the LCHP.

LCHP primary care case managers are paid a monthly case management fee for $3.00 per recipient assigned to them. The LCHP is not a risk-based capitated program. Instead, the monthly case management fees are paid through the Department's fee-for-service program.

The LCHP is the Plan Administrator for this program. As the Plan Administrator, LCHP is responsible for the following activities:

- o Recruit, enroll, and provide technical support for LCHP providers;
- o Assist recipients in selecting a provider;
- o Process changes in provide/recipient assignments;
- o Compile and submit data to the Department to enable them to pay case management fees to LCHP providers;
- o Notify providers of the recipients enrolled with them;
- o Notify recipients of their enrollment with the provider;
- o Issue membership cards to recipients enrolled in the LCHP;
- o Utilize surveys to monitor recipients satisfaction with the LCHP; and
- o Monitor quality and appropriateness of services and referrals provided by the primary care case managers by reviewing paid claims history, conducting on-site visits, and reporting results to the Department.

Enrollment in the LCHP is mandatory unless a recipient chooses to enroll in a Health Maintenance Organization. The Lancaster County Assistance has responsibility of informing all eligible recipients about their option of choosing either the LCHP or an HMO.

Recipients of the LCHP receive their care through their primary care case manager. The primary care case manager provides most medical services. When the situation warrants, the primary care case manager will refer the recipient to a specialist or, if appropriate, a community-based service agency. If the recipient chooses to receive services from another provider without notifying or receiving a referral from their LCHP provider, the Medical Assistance Program may not pay for these services. In

some instances, the recipients may self-refer to receive services from providers other than the LCHP provider. Examples of these types of services include:

- o Emergency and ambulance services;
- o Impatient hospital care and residential treatment;
- o Prescription drugs or medical equipment;
- o Dental services;
- o Eye examinations and glasses;
- o Family planning services;
- o Obstetrical/gynecological services;
- o Mental health and drug and alcohol services;
- o Nursing home or ICF/MR care; or
- o Diagnostic and laboratory services.

These services are excluded from the LCHP provider referral process for the following reasons:

- o The Department already has activities in place to monitor utilization;
- o They are specifically exempt from federal regulations;
- o Because they are services not routinely available from a primary care provider and would always require referral placing a burden on the LCHP provider; or
- o The service is one usually accessed by a recipient in crisis and requiring a referral might deter the recipient from seeking treatment.

In addition, there are exclusions to enrollment in the LCHP by recipients. These are:

- o Have Medicare or other insurance;
- o They are residing in a nursing facility or ICF/MR'
- o Are enrolled in another managed care program;
- o Have an eligibility period that is less than three months;
- o Live in an area other than Lancaster County;
- o Have an eligibility period that is only retroactive;
- o Are in lock-in status;
- o Are enrolled only in "TR" category of extended MA coverage for which they are paying a premium;
- o AFDC category recipients designated as a federal or state foster care or subsidized adoption cases if residence is outside Lancaster County.
- o AFDC category pregnant women receiving coverage of prenatal services during period of presumptive eligibility;
- o Individual in inpatient care status for more than 60 consecutive days; or
- o Recipient of Stae Blind Pension.

Pennsylvania

HealthChoices

PROGRAM NAME: HealthChoices

ORIGINAL IMPLEMENTATION DATE: 9/1/94

CONTACT: Thomas M. Orlowaki
(717) 772-6292

EXPIRATION DATE: 9/31/96

GEOGRAPHIC AREAS: Berks, Bucks, Chester, Delaware, Montgomery and Philadelphia Counties

NUMBER OF ENROLLEES: 650,000

FFS (PCCM) OR PRE-PAID OR BOTH: Pre-Paid capitated

STATUTES UTILIZED: 1915(b)(1), 1915(b)(2), 1915(b)(3) & 1915(b)(4)

STATUTES WAIVED: 1902(a)(1); 1902(a)(10)(B); 1902(a)(23); & 1902(m)(30).

POPULATION CATEGORIES INCLUDED: AFDC;GA; SSI; Health Beginnings; and Healthy Horizons (over 65).

POPULATION CATEGORIES EXCLUDED: Presumptive eligibles; monthly spend downs, pre-release grants; one time issuances; residents of nursing homes; Medicare buy-in-only; and State blind pension; retroactive eligibility only; recipients admitted to a state mental hospital, state mental retardation center, long-term acute psychiatric facility, and residential treatment facility.

SERVICES INCLUDED: All Medicaid services currently covered under FFS except: nursing home care, general transportation services, extended acute psychiatric hospital, residential treatment facilities, private ICF/MR, case management (MH/MR), early intervention, education rehabilitation service, family-base therapy, crisis intervention, and funeral director.

PCP PROVIDER TYPES: Physician, hospital outpatient clinic, independent medical clinic, rural health center, federally qualified health center, and school-based health center.

FUTURE PLANS: Targeted date for implementation is July 1, 1996.

Pennsylvania Health Choices Program

On November 18, 1993, the United States Health Care Financing Administration (HCFA) approved the Pennsylvania Department of Public Welfare's waiver request to expand managed care for medical assistance clients in Berks, Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties.

The waiver program, named the HeatlhChoices Program, is authorized under Section 1915(b) of the United States Social Security Act. Sections of the Act relevant to this waiver request include:

- Section 1902(a)(1) - Statewideness
- Section 1902(a)(10)(B) - Comparability of Services
- Section 1902(a)(23) - Freedom of Choice
- Section 1902(a)(30) - Upper Payment Limit

The objective of the waiver is to ensure access to quality health care for more than 650,000 Medicaid clients; to provide preventive health care; and to control costs by reducing unnecessary use of services. The basic concept of the HealthChoices Program is simple. Clients will be enrolled in Health Maintenance Organizations (HMOs). The HMOs will provide comprehensive health care services and will approve all necessary speciality services. Clients will have full access to necessary emergency and family planning services under the waiver.

The HMOs will assist clients in using the health care system, and will closely monitor their health care needs. The HMO will be responsible for coordinating their clients' primary health care, as well as other medical and rehabilitative services.

Medical assistance clients enrolled in the HMOs will be restricted to receiving medical care from the HMO, or from specialists to whom the clients are referred.

One out of nine Pennsylvanians currently rely on the Commonwealth's Medical Assistance Program for their health care at an annual cost of more than $5.8 billion. The state's health care program for low-income residents consumes more than 24 percent of the state budget, and program costs have more than doubled in the last four years.

Much of the increase in the Medical Assistance Program can be attributed to the fact that many clients do not have a family doctor, resorting, instead, to costly hospital emergency room visits for health care. The HealthChoices Program will be similar to the successful HealthPASS Program and other managed

care plans currently serving medical assistance clients in the Greater Philadelphia and Pittsburgh areas. The current programs provide quality comprehensive health care services to more than 450,000 Medicaid clients, many of whom have voluntarily chosen managed health care. More than 40 percent of the Commonwealth's 1.7 million Medical Assistance clients will be covered under the HealthChoices Program. The following information summarizes the Department's plans for managed care in Pennsylvania through this 1915(b) Waiver Program.

- The waiver allows the Department to operate the HealthChoices Program for a two-week period, the maximum time allowed by the federal law. The Department will seek a renewal of the waiver after the two-year period.

- The waiver allows the Department to implement mandatory managed care for Medical Assistance clients in Berks, Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties.

- All current Medicaid services will be covered under the waiver, with a few exceptions, like nursing home services. Mental health and drug and alcohol services will be included in the first year of the HealthChoices Program for Philadelphia County only. These services will be included in the second year of the HeatlhChoices Program in the five remaining counties.

- Services in the HealthChoices Program include, but are not limited to: office visits; prescriptions; dentist; podiatrist; medical supplies; chiropractor, optometrist; ambulance, home health care, family planning, nurse midwife, hospice, EPDST services, audiology/EPDST, occupational therapy/EPDST , psychological services; physical therapy, speech therapy, AIDS waiver services, case management, renal dialysis, and inpatient and outpatient hospitalizations.

- Medical assistance clients in the six-county region must enroll in an HMO. Clients who do not select an HMO will be assigned to a managed care arrangement in their region. Clients, however, can initiate a change in HMO at anytime.

The Department competitively bid risk-comprehensive contracts for the six-county region. The Department procured the contracts under the Commonwealth's Request for Proposal (RFP) process. However, the winning contractors have not been announced. Medicaid and Medicare clients can constitute no more than 75 percent of the total enrollment of the HMO's clientele. The Department can request federal waivers to allow the HMOs time to meet this requirement. The Department intends to expand mandatory managed care in the future. The expansion effort will require a HCFA-approved waiver or waiver modification.

South Carolina

High Risk Channeling Project (HRCP)

PROGRAM NAME: High Risk Channeling Project (HRCP)

ORIGINAL IMPLEMENTATION DATE: April 1, 1986

CONTACT:
Bunny Jones (803) 253-6374
Department of High Risk and Maternal Care

EXPIRATION DATE: 1997

GEOGRAPHIC AREAS: Statewide

NUMBER OF ENROLLEES: 3,757

FFS (PCCM) OR PRE-PAID OR BOTH: FFS

STATUTES UTILIZED: 1915 (b) (1); 1915 (b) (4) of the Social Security Act

STATUTES WAIVED: 1902 (a) (10) and 1902 (a) (23) of the Social Security Act

POPULATION CATEGORIES INCLUDED: Medicaid eligible pregnant with medical conditions which place them at high risk for poor birth outcomes (e.g. women with diabetes, alcohol and /or drug dependent, etc.) and infants with serious medical conditions Statewide.

POPULATION CATEGORIES EXCLUDED: All Medicaid eligible recipients other than pregnant women and infants up to one year of age with serious medical conditions.

SERVICES INCLUDED: Targeted Case Management, High Risk Nutrition Services, High Risk Social Work Services, Parental care must be provided by an obstetritian and delivery of the neonate must occur in a medical center that is equipped to handle any medical crisis situations that may occur (Level II or Level III hospital).

PCP PROVIDER TYPES: Obstetrical Care: Obstetricians, FQHCs, Health Departments. Neonatal care: Neonatologist, FQHCs, Family Practice Providers, and General Practitioners.

FUTURE PLANS: For October 1995, it has been proposed the case management, nutritional services, and social work services that were ordinally mandated services will now be provided only when there is a demonstrated need. Prenatal care that is rendered by an obstetrician and delivery of neonate in a Level II or Level III hospital remain mandated services.

High Risk Channeling Project (HRCP)

The High Risk Channeling Project (HRCP) is a waived program which has been in effect since April, 1986. The most recent Waiver renewal was awarded to the Department of Health and Human Service June 30, 1992. HRCP is a state -wide project designed to channel high risk pregnant women into appropriate levels of care. Mandated HRCP services include prenatal care by an obstetrician and delivery of infants in Level II or Level III hospitals. Case Management up to a year post partum, nutritional assessment and social work assessment services have historically been mandated for all high risk pregnant women and infants. Currently, the State is proposing changing this to provide these services only if there is a demonstrated need. HRCP services are provided primarily by the South Carolina Department of Health and Environmental Control (DHEC), the State Maternal and Child Health Block Grant Agency.

South Carolina

Health Access Plan (SCHAP)

PROGRAM NAME: South Carolina Health Access Plan (SCHAP)	*ORIGINAL IMPLEMENTATION DATE:* February 1, 1993
CONTACT: Jim Young (803) 253-6177	*EXPIRATION DATE:* September 30, 1996
GEOGRAPHIC AREAS: Horry and Marion counties	*NUMBER OF ENROLLEES:* 1,181

FFS (PCCM) OR PRE-PAID OR BOTH: FFS (PCCM)

STATUTES UTILIZED: 1915 (b)

STATUTES WAIVED: 1902 (a)(1), 1902 (a)(10), 1902 (a)(10)(B), 1902 (a)(23)

POPULATION CATEGORIES INCLUDED: Uninsured employees and families of small businesses

POPULATION CATEGORIES EXCLUDED: All recipients that do not fall in the above categories

SERVICES INCLUDED: All medically necessary services except pregnancy services, neonatal, organ transplant, nursing home, ESRD, institutional services, residential treatment facilities, administrative days for acute hospital care.

PCP PROVIDER TYPES: Family Practice, General Practice, Internal Medicine, Pediatrics, OB/GYN

FUTURE PLANS: Effort in concert with HCFA under way to extend demonstration project for additional period of three years. Legislation amendments have been prepared and await submission by appropriate congressional staff.

South Carolina Health Access Plan (SCHAP)

The South Carolina Health Access Plan (SCHAP) is a federal demonstration project that provides health insurance coverage to low income employees and employers by using the Medicaid program structured in a managed care insurance environment, with employers and employees paying premiums approximating the 30% of their health care costs. These are funded through grants from the Duke Endowment, the American Medical Association, and the federal and state governments. The program operates in Horry and Marion counties and are provided to local small businesses on a voluntary basis. Health insurance premiums are collected monthly through the employer and matched against federal Medicaid funds to pay participating health care providers. The use of managed Care is a key feature of the project. Members have the freedom of choice to select a primary care physician from participating physicians in the area to manage their care. The physicians receives Medicaid reimbursement and a $4.00 per member/per month management fee for accepting coordinates referral, responsibility for the patient's care. The physician determines the need for care, coordinates referral, insures access to medical care 24 hours per day, and monitors all treatment provided to the patient.

Eligible Business

Located in Horry and Marion counties. Less than 100 employees. 50% of employees make less than 150% of federal poverty level (FPL). FPL for family of 4 is 1,850 per month, or $22,200 per year. Participation of at least 3 employees. No health insurance for past 12 months.

Eligible Employees

Family income less than 150% of FPL. Resident of South Carolina. Full time employee (9 months/30 hours). Less than 65 years of age. No major health insurance.

Health Benefits

All South Carolina Medicaid services except some adult and federally mandated exclusions (no pregnancy coverage- Medicaid covers this up to 185% of poverty, long term care, nursing facilities, or state institutional care).

Premiums

Single - $39.94/month, employee portion - $9.98. Family - 99.29/month, employee

portion $ 24.82. Employees with income under 100% of FPL do not pay a premium.

Membership and Health Cost Total Paid

177 businesses enrolled 2,447 members. 80 physicians in primary care network, 14 physicians, 19 businesses, and 1,266 members disenrolled to date due to loss of job, closing business, or moving out of demonstration area. Health Access Board, and 7 member Physician Advisory Council. $803,423.97 in premiums collected through September, 1995, plus $1,955,235.14 federal match equals $2,758,659.11 available for services. $1,620,585.24 health care expenditures through 09/15/95, $1,128,151.12 available for claims from premium balance and federal match, and $77.25. Third party liability (TPL) recoupment. Average monthly health cost = $71.93.

South Dakota

Provider and Recipient in Medicaid Efficiency Program (PRIME)

PROGRAM NAME: Provider and Recipient in Medicaid Efficiency Program--PRIME	*ORIGINAL IMPLEMENTATION DATE:* September 9, 1993
CONTACT: Sara Green 605-773-5463	*EXPIRATION DATE:* August 30, 1995
GEOGRAPHIC AREAS: close to statewide (expanding incrementally)	*NUMBER OF ENROLLEES:* 21,000

FFS (PCCM) OR PRE-PAID OR BOTH: FFS

STATUTES UTILIZED: 1915(b)(1) and (3)

STATUTES WAIVED: 1902(a)(23), (1), (10)

POPULATION CATEGORIES INCLUDED: AFDC/AFDC-related; SSI

POPULATION CATEGORIES EXCLUDED: Medicare; NF; ICF-MR

SERVICES INCLUDED: physician, inp. hosp, outpt. Hosp, psychiatric services, pharmacy, DME, ophthamology

PCP PROVIDER TYPES: Physicians, Rural Health Clinics, Federally Qualified Health Clinics, and Indian Health Clinics

FUTURE PLANS: expand statewide

South Dakota Prime

Under PRIME, approximately 75% of Medicaid-eligible recipients will be required to participate in the program, to include AFDC, AFDC-related, and SSI recipients. A large portion of those not required to participate are those who are also Medicare beneficiaries. NF residents and Foster care children are also not required to participate.

As of June, 1995, PRIME has been implemented in nearly 40 counties. A four month implementation process occurs in each county to prepare for manage care. The implementation process includes provider contact and provider and recipient training on the changes occurring with the PRIME program.

The program's pilot county, Codington, has been operational since 1993, with first year savings in that county alone estimated at $160,000. The Department of Social Services' SFY 1996 budget request was reduced by over $4.5 million as a direct result of the managed care initiative, including a reduction of over $3.6 million in inpatient and outpatient hospital payments.

Texas

LoneSTAR Health Initiative; Tri-County Enhanced PCCM

PROGRAM NAME: Tri-County Enhanced PCCM; LoneSTAR Health Initiative	ORIGINAL IMPLEMENTATION DATE: December 1, 1993
CONTACT: Linda Wertz (512) 338-6508	EXPIRATION DATE: November 30, 1995
GEOGRAPHIC AREAS: Counties of Jefferson, Chambers & Galveston	NUMBER OF ENROLLEES: 33,402

FFS (PCCM) OR PREPAID OR BOTH: PCCM

STATUTES UTILIZED: 1915(b)(1), 1915(b)(3)

STATUTES WAIVED: 1902(a)(1), 1902(a)(10)(B), 1902(a)(23)

POPULATION CATEGORIES INCLUDED: AFDC and Related Groups

POPULATION CATEGORIES EXCLUDED: SSI disabled, refugees, foster care, Medicare

SERVICES INCLUDED: Inpatient hospital, outpatient hospital, rural health clinic, laboratory, x-ray, EPSDT, family planning, physician, home health, FQHC, psychiatric, pharmacy

PCP PROVIDER TYPES: general practice, family practice, pediatrics, internal medicine, obstetrics and gynecology, certified nurse midwife, advance nurse practitioner

FUTURE PLANS: Pursuing 1115 waiver (submitted to HCFA 8/31/95); expanding existing PCCM to include three additional counties to be implemented on December 1, 1995; exploring other areas of the State to expand Medicaid managed care under 1915(b) waiver authority.

Texax LoneSTAR; Tri-County Enhanced PCCM

The Texas Department of Health has implemented a Medicaid managed care project under a 1915(b) waiver which is referred to as the LoneSTAR Health Initiative. The acronym STAR stands for State of Texas Access Reform. The program is designed to achieve four main objectives: improved access to care, improved quality of care, improved utilization patterns, and improved cost effectiveness.

An enhanced primary care case management model (PCCM) was implemented in Jefferson, Chambers, and Galveston Counties on December 1, 1993. Under this system, primary care providers (PCPs) receive fee-for-service reimbursement, plus a monthly case management fee for providing primary care services.

Clients are given the opportunity to select a participating primary care provider who will act as the gatekeeper for their medical services. A PCP is defined as a general practitioner, family practitioner, pediatrician, internist, obstetrician/gynecologist, certified nurse midwife or an advanced nurse practitioner specializing in family practice or pediatrics. Clients maintain freedom of choice for emergency services, family planning, and EPSDT services. The LoneSTAR program also offers some enhanced benefits such as the removal of the Medicaid three prescription drug limit for adults and an annual physical is covered for each adult client.

Participation in the LoneSTAR Health Initiative is mandatory for clients who receive AFDC and AFDC-related benefits. Elderly people, people with disabilities, refugees, foster care, and medically needy individuals are excluded from the program. These clients and the remaining portion of the Texas Medicaid population continue to receive benefits through the traditional fee-for-service Medicaid program.

The Texas Department of Health is planning for expansion of Medicaid managed care into other areas of the State.

CONTACT: Linda Wertz
Director of Medicaid
Texas Department of Health
1100 West 49th Street
Austin, Texas 78756-3168
Telephone: (512) 338-6508

Texas

LoneSTAR Travis County HMO/PHP Model

PROGRAM NAME: LoneSTAR Travis County HMO/PHP Model

ORIGINAL IMPLEMENTATION DATE: August 1, 1993

CONTACT: Linda Wertz
(512) 338-6508

EXPIRATION DATE: July 31, 1995

NUMBER OF ENROLLEES: 29,754

GEOGRAPHIC AREAS: Travis County

FFS (PCCM) OR PREPAID OR BOTH: HMO/PHP

STATUTES UTILIZED: 1915(b)(1), 1915(b)(2), 1915(b)(3), 1915(b)(4)

STATUTES WAIVED: 1902(a)(1), 1902(a)(10), 1902(a)(23), 1902(a)(30)

POPULATION CATEGORIES INCLUDED: AFDC and Related Groups

POPULATION CATEGORIES EXCLUDED: SSI disabled, refugee, foster care, Medicare

SERVICES INCLUDED: Inpatient/outpatient hospital, professional services, lab and x-ray, ambulance services, home health, rural health, hearing aid, chiropractic, certified nurse ,midwife, birthing center, transplant, FQHC, LPC, adult well check, family planning, genetics, EPSDT medical and dental, EPSDT comprehensive care program, pregnant women and infants case management, early childhood intervention, MHMR, MRDA, TCADA, SHARS, triage

PCP PROVIDER TYPES: Internist, OB-GYN, family practitioners, pediatricians, general practitioners, advanced nurse practitioner, certified nurse midwife

FUTURE PLANS: Pursuing 1115 waiver (submitted to HCFA 8/31/95); expanding existing PCCM to include three additional counties to be implemented on December 1, 1995; exploring other areas of the State to expand Medicaid Managed Care under 1915(b) waiver authority.

Texas LoneSTAR, Travis County

The Texas Department of Health has implemented a Medicaid managed care project under a 1915(b) waiver which is referred to as the LoneSTAR Health Initiative. The acronym STAR stands for State of Texas Access Reform. The program is designed to achieve four main objectives: improved access to care, improved quality of care, improved utilization patterns, and improved cost effectiveness.

The project was implemented in Travis County on August 1, 1993. Clients select from two competing health plans which includes a federally qualified health maintenance organization (HMO) and a pre-paid health plan (PHP). The HMO is at full risk and the PHP assumes risk for physician, laboratory, and x-ray services only.

Clients are given the opportunity to select a health plan and a participating primary care provider (PCP) who will act as the gatekeeper for their medical services. Clients maintain freedom of choice for emergency services, family planning, and EPSDT services. The LoneSTAR program also offers some enhanced benefits such as the removal of the Medicaid three prescription drug limit for adults and an annual physical exam is covered for each adult client.

Participation in the LoneSTAR Initiative is mandatory fore clients who receive AFDC and AFDC related benefits. Elderly people, people with disabilities, refugees, foster care, and medically needy individuals are excluded from the programs. These clients and the remaining portion of the Texas Medicaid population continue to receive benefits through the traditional fee-for-service Medicaid program.

The Texas Department of Health is planning for expansion of Medicaid managed care into other areas of the State.

Contact: Linda Wertz
Bureau Chief
Texas Department of Health
1100 West 49th Street
Austin, Texas 78756-3168
Phone (512) 338-6508

Texas

LoneSTAR Select I

PROGRAM NAME: LoneSTAR Select I

ORIGINAL IMPLEMENTATION DATE: 9/1/94

CONTACT:

EXPIRATION DATE: 8/31/96

GEOGRAPHIC AREAS: approximately 27 Metropolitain Service Areas (MSAs) in Texas

ENROLLEES: N/A

FFS (PCCM) OR PRE-PAID OR BOTH: N/A

STATUTES UTILIZED: 1915(b)(4)

STATUTES WAIVED: 1902(a)(1), 1902(a)(13)(a), 1902(a)(13)(B), 1902(a)(23)

POPULATION CATEGORIES INCLUDED: All Medicaid eligibles

POPULATION CATEGORIES EXCLUDED: Medicare dual-eligibles, enrolled in one of the State' managed care plans

SERVICES INCLUDED: nonemergency treatment, inpatient care

PCP PROVIDER TYPES: Hospitals

Texas LoneSTAR Select I

The object of the Texas LoneSTAR Select I Selective Contracting program is to interject competition among participating providers to operate their selective contracting program for Inpatient Hospital services. Participation in the waiver is virtually transparent to the beneficiaries since almost all of the hospitals participating in Medicaid before the waiver continue to participate under the waiver.

Texas

LoneSTAR Select II

PROGRAM NAME: LoneSTAR Select II	*ORIGINAL IMPLEMENTATION DATE:* March 1, 1995
CONTACT: Linda Wertz (512) 338-6508	*EXPIRATION DATE:* February 29, 1997
GEOGRAPHIC AREAS: Dallas Fort Worth, Houston, Corpus Christi, and San Antonio	*NUMBER OF ENROLLEES: NA*

FFS (PCCM) OR PRE-PAID OR BOTH:

STATUTES UTILIZED: 1915(b)(4)

STATUTES WAIVED:

POPULATION CATEGORIES INCLUDED: Services will apply only to covered inpatient psychiatric services for children under the age of 21.

POPULATION CATEGORIES EXCLUDED: Beneficiaries over the age of 21, Medicare/Medicaid dual eligibles; will not apply in emergency room care or true emergency admissions.

SERVICES INCLUDED: Non-emergency inpatient psychiatric services for children reimbursed by the Medicaid program.

PCP PROVIDER TYPES: Targeted towards facilities referred to as "applicable freestanding psychiatric facilities for children" or AIPFCs which include freestanding psychiatric hospitals and non-hospital providers approved by the State to provide non-emergency inpatient psychiatric care.

Texas LoneSTAR Select II

The LoneSTAR Select II waiver proposal enables the State to contract selectively with inpatient psychiatric facilities that provide non-emergency inpatient psychiatric services in five urban metropolitain statistical areas (MSAs). The central concept underlying the proposal is the use of competition and market forces as the basis for negotiating contracts with providers of inpatient psychiatric services to do the following: (1) assure adequate access to appropriate , high quality, cost-effective inpatient services for Medicaid children; (2) contain overall expenditures for non-emergency inpatient services; and (3) facilitate an orderly transition to a Medicaid program design philosophy using an approach emphasizing primary care to minimize unnecessary use of inpatient psychiatric care.

Programs that currently require pre-authorization of inpatient psychiatric services for children, and concurrent medical review of inpatient psychiatric services, will be super-imposed on LoneSTAR Select II program. Because the State will maintain its records to compare against paid capitation rates, the infrastructure is in place to enable the State to monitor medical outcomes related to inpatient psychiatric care for future years.

Assuring access for beneficiaries will be accomplished through several mechanisms, including quarterly review of critical data, prompt investigation of complaints, and annual review of detailed Zip Code data. Contracted AIPFCs will be monitored to determine compliance with the staffing and program hours to which they have committed. Appropriate, good quality care is a high priority. There will be an independent evaluation of the overall waiver program with special emphasis on cost effectiveness, improved access to care, and services of enhanced quality. This evaluation will be submitted three months prior to the end of the approved waiver period.

Utah

Choice of Health Care Delivery

PROGRAM NAME: Choice of Health Care Delivery	*ORIGINAL IMPLEMENTATION DATE:* 1982
CONTACT: Ed Furia (801)538-6505	*EXPIRATION DATE:* February 26, 1996
GEOGRAPHIC AREAS: Mandatory in Weber, Salt Lake, Utah, and Davis counties; optional in rural counties	*NUMBER OF ENROLLEES:* 37,500

FFS (PCCM) OR PRE-PAID OR BOTH: Both

STATUTES UTILIZED: 1915(b)(1) and (2)

STATUTES WAIVED: 1902(a)(23) and (1)

POPULATION CATEGORIES INCLUDED: AFDC/AFDC-related; SSI/SSI-related; Medically Needy

POPULATION CATEGORIES EXCLUDED: NF-ICF/MR; Medicare

SERVICES INCLUDED: physician; inpatient and outpatient psychiatric services; certain surgical procedures

PCP PROVIDER TYPES: Physician, Osteopath, Nurse Midwife, Freestanding Clinics, FQHC, Local Health Dept., HMO

FUTURE PLANS: mandate HMO enrollment in the four urban counties

Utah Choice of Health Care Delivery

Choice of Health Care Delivery was implemented in 1982. In urban areas, Medicaid clients are asked to choose between an HMO or a primary care physician to manage their care. Written referrals to a specialist must be given by the PCP.

A unique feature of the program is the use of Health Program representatives (HPRs). The role of HPRs is to explain the various health care options available and to assist recipients in making a health care choice that is best for them. The HPRs also function as health educators and help to inform clients about the responsible use of services. Furthermore, they function as client advocates in assisting individuals in getting the health and social services they need.

Utah has also initiated a program to encourage recipients to utilize their primary care physician instead of the emergency room. Recipients that seek routine care through the emergency room are redirected back to their primary care physicians for these services. A triage fee is made to the emergency room physician for their assessment.

Utah

Prepaid Mental Health Program

PROGRAM NAME: Prepaid Mental Health Program	*ORIGINAL IMPLEMENTATION DATE:* September 9, 1991
CONTACT: Zohreh Speckman (801) 538-6499	*EXPIRATION DATE:* November 16, 1995
GEOGRAPHIC AREAS: 8 of 11 Mental Health Catchment areas	*NUMBER OF ENROLLEES:* 80,000

FFS (PCCM) OR PRE-PAID OR BOTH: Prepaid

STATUTES UTILIZED: 1915(b)(4)

STATUTES WAIVED: 1902(a)(23) and (a)(1)

POPULATION CATEGORIES INCLUDED: AFDC, SSI, Medically Needy

POPULATION CATEGORIES EXCLUDED: Medicare

SERVICES INCLUDED: Mental Health clinic, inpatient psychiatric care, targeted case management

PCP PROVIDER TYPES: community mental health centers

FUTURE PLANS: expand statewide

Utah Prepaid Mental Health Program

The purpose of the Prepaid Mental Health program is to counteract escalating costs, inadequate methods of assuring continuity of care, and a lack of provider accountability in controlling utilization rates.

Based on the analysis of utilization data during the first two years of the waiver, reliance on the use of inpatient psychiatric care has been reduced under the PMHP. Reductions in the number of inpatient days for both children and adults is dramatic, yet counterbalanced by the contractors' abilities to provide alternatives to hospitalization. Alternatives ranged from intensified day treatment to residential care facilities.

Coordinated mental health care was another objective of the program, particularly that the mix and array of inpatient to outpatient services under the PMHP would lead to an increase in the utilization of outpatient services under the program. Consistent with this thesis, there was an overall increase in the utilization of outpatient services in capitated areas during the waiver's first two years, although at a lower rate than in the fee-for-service areas.

Analysis of expenditures also indicates that the PMHP had an impact in slowing down the overall growth in expenditures for Medicaid mental health services. Overall, comparisons of costs with and costs without the waiver indicate that from an upper payment limit perspective or utilization perspective, the program has yielded savings.

Virginia

Medallion

PROGRAM NAME: Medallion

ORIGINAL IMPLEMENTATION DATE: March 1992

CONTACT: Thomas McGraw
(804)371-6400

EXPIRATION DATE: June 30, 1996

GEOGRAPHIC AREAS: Statewide

NUMBER OF ENROLLEES: 300,000

FFS (PCCM) OR PRE-PAID OR BOTH: FFS (PCCM)

STATUTES UTILIZED: 1915(b)

STATUTES WAIVED: Sections 1902(a)(1),(10), and (23)

POPULATION CATEGORIES INCLUDED: AFDC, AGED, BLIND, DISABLED

POPULATION CATEGORIES EXCLUDED: Long-Term Care, Nursing Homes, State Mental Institutions, Hospice, HCFA Waivered Programs, Aliens/Refugees, Spend down, Foster Care Children, Persons with Third party insurance.

SERVICES INCLUDED: Primary Care including EPSDT Services

PCP PROVIDER TYPES: General/Family Practitioners, Pediatricians, Internists, Obstetricians/Gynecologists

FUTURE PLANS: Expanded rural access, Enhanced emergency room policy development, Client Education

The Virginia Medallion Program

o First step in Virginia Medicaid Managed Care plan

o Provides a medical home for the patient and provides coordinated and continuous care. Provider provides 24 hours access

o Patient selects Primary Care provider from network list, however if no action is taken the client is assigned a provider through a pre-assignment method.

o Expansion is based on the provider network and overall access to care.

o Program includes AFDC (Aid to Families with Dependent Children) and AFDC related individuals and the Aged, blind and Disabled (who do not have third party insurance, waivers, foster care or institutionalized in a long term facility or spend down)

o Statewide expansion completed in 1995--136 cities and counties

FIVE GOALS OF MEDALLION:

1. Provide patient with a Primary Care Provider
2. Increase access to care
3. Provide for Continuity of Care
4. Promote patient responsibility and compliance
5. Increased physician participation in Medicaid

MEDALLION PRIMARY CARE PROVIDERS:

o Pediatricians, General and Family Practitioners, Obstetrics and Gynecologists and Internists
o Primary care Provider's name and 24 hours number if printed on the MEDALLION card
o Coordinates all primary care (well and sick care)
o Refers patients to specialists and admit patients to hospitals

MEDALLION REFERRALS ARE REQUIRED ON ALL SERVICES EXCEPT:

Emergency Room Services, Family Planning Services, Obstetrics, Durable Medical Equipment & Supplies, Routine Vision Care, School Based Services (Children Only), Dental Services (Children Only), Immunizations (Children Only)

Washington

Hospital Selective Contracting

PROGRAM NAME: Hospital Selective Contracting

ORIGINAL IMPLEMENTATION DATE: April 1, 1988

CONTACT: Alan McMullen
(360) 586-6698

EXPIRATION DATE: December 31, 1996

GEOGRAPHIC AREAS: Seattle, South King, East King County, Pierce County, Vancouver, Tri-Cities, Yakima and Spokane.

NUMBER OF ENROLLEES: NA

FFS (PCCM) OR PRE-PAID OR BOTH: Not applicable

STATUTES UTILIZED: 1915(b)(4)

STATUTES WAIVED: In Section 1902 of the Act: (a)(23) related to freedom of choice, (a)(13)(A) related to findings and assurances regarding payments rates, (a)(1) related to state wideness of rates.

POPULATION CATEGORIES INCLUDED: All

POPULATION CATEGORIES EXCLUDED: None

SERVICES INCLUDED: All inpatient hospital care except emergency, neonatal care, rehabilitation, long term care, psychiatric services, detox, chemically dependent pregnant women and persons with AIDS.

PCP PROVIDER TYPES: Not applicable

FUTURE PLANS: To request a waiver amendment to expand the current contracts to additional areas.

Washington Hospital Selective Contracting

The Washington State Hospital Selective Contracting Program began on April 1, 1988. Washington State was one of three states (California and Illinois) to have such a program.

As of June, 1995 Washington had contracted with 23 hospitals in six regions of the state; Seattle, South King County, Vancouver, Tri Cities, Yakima and Spokane. Effective 12/22/95, the waiver was expanded to include East King County and Pierce County.

The contracted rates are competitively negotiated bid for all inpatient DRG reimbursed services except neonatal, rehabilitation, psychiatric services, detox, chemically dependent pregnant women, and persons with AIDS. Hospitals not contracted within a contract area can only be reimbursed for the services not included with contracted hospitals in addition to emergency care and maternity inpatient care.

The contracts with the hospitals are for a negotiated rate and continue until either the hospital or the state discontinues the contract or the hospital renegotiates the rate after a period of at least 12 months.

The program was worked very well in reducing expenditures while continuing to provide excellent inpatient hospital care.

Future plans include expanding the program to other areas of the State.

Washington

Coordinated Community Mental Health Plan

PROGRAM NAME: Coordinated Community Mental Health Plan	*ORIGINAL IMPLEMENTATION DATE:* June 1, 1993
CONTACT: David Dula (360)753-4448	*EXPIRATION DATE:* June 30, 1997
GEOGRAPHIC AREAS: Statewide	*NUMBER OF ENROLLEES:* FYU 1994 565,000

FFS (PCCM) OR PRE-PAID OR BOTH: Pre-paid capitation

STATUTES UTILIZED: 1915(b)(1) and 1915(b)(4)

STATUTES WAIVED: 1902(a)(1), 1902 (a)(10)(B), 1902(a)(23)

POPULATION CATEGORIES INCLUDED: All Medicaid eligible clients, except residents of state owned institutions. Native Americans maintain access to Indian Health and tribal clinics if preferred.

POPULATION CATEGORIES EXCLUDED: Residents of state owned institutions.

SERVICES INCLUDED: Rehabilitation services (all services provided by a certified community mental health center).

PCP PROVIDER TYPES: Primary care not included within scope.

FUTURE PLANS: Apply prepaid capitated methodology to inpatient psychiatric treatment.

Washington Coordinated Community Mental Health Plan

This waiver, currently being phased in, requires the client to access to outpatient community mental health services through a regional support network (RSN) that acts as a gate keeper to promote access to appropriate care. RSNs are generally formed at the county level; however, in some areas several counties may unite to form a single RSN. RSNs range in size from a single county to the largest which includes 11 counties.

The RSN contracts with the Medicaid agency as a prepaid health plan. It is reimbursed by the Medicaid program on a prepaid capitated basis and, in turn, contracts with the individual community mental health centers, under various payment scenarios at the discretion of the RSN, to provide services.

The community mental health centers provide the following services: crisis services, stabilization services, intake evaluation, special population evaluation, interdisciplinary evaluation for nursing home resident, psychological assessment, medication management, individual treatment services, group treatment services, adult day treatment, adult acute diversion services, children and adolescent day treatment, child and adolescent acute diversion services, and family therapy. In addition higher need clients receive individualized and tailored care planning. Needs driven planning and services are offered with the goal to provide comprehensive normalized support of consumers in the community, consistent with their age, sex and culture.

Payments by the Medicaid agency to the RSN are monthly on a prospective basis using three levels or tiers of capitated rates: Tier 1 - all Medicaid recipients who reside in the area served by the RSN; Tier 2 - all eligibles under Tier 1 who, in addition, are seriously emotionally disturbed children, chronically mentally ill, or seriously disturbed at risk of chronic mental illness; and Tier 3 - all eligibles under Tier 2 who, in addition, meet additional criteria as being more difficult and costly to serve.

Washington

Healthy Options

PROGRAM NAME: Healthy Options

ORIGINAL IMPLEMENTATION DATE: October 1, 1993

CONTACT: Joan Bantz (360) 586-1099

EXPIRATION DATE: December 31, 1995

GEOGRAPHIC AREAS: Statewide

NUMBER OF ENROLLEES: 375,915

FFS (PCCM) OR PRE-PAID OR BOTH: Both: over 90% prepaid capitated, less than 10% PCCM.

STATUTES UTILIZED: 1915(b)(1), 1915(b)(4)

STATUTES WAIVED: 1902(a)(1), 1902(a)(10)(B), 1902(a)(23)

POPULATION CATEGORIES INCLUDED: AFDC categorically needy, SSI categorically needy, pregnant women to 185% of FPL, children to age 19 to 200% FPL.

POPULATION CATEGORIES EXCLUDED: Medicare eligibles, individuals with 3rd party coverage, individuals more than 25 miles of 45 minutes from nearest service site, Medically Needy eligibles, or eligible for Tribal Health Services and elect not to participate in managed care.

SERVICES INCLUDED: Hospital, physician/ARNP, Licensed midwife, eye exam, lab and radiology, durable medical equipment, podiatry, home health services, hospice, ambulance, blood & products, audiology, therapies, kidney dialysis, special duty nursing, dietitian, pharmacy, Immunizations, STD screens & follow ups, family planning, HIV testing, and TB screens and follow-ups.

PCP PROVIDER TYPES: Family practice, general practice, internists, pediatricians, ARPNs, and PAs.

FUTURE PLANS: Expand coverage for certain SSI populations between September 1995 and December 1996.

Washington Healthy Options

Healthy Options is the managed care program for certain groups of Department of Social and Health Services (DSHS) clients who receive medical assistance. The Medical Assistance Administration (MAA) began implementing Healthy Options statewide as a mandatory program in 1993. In Healthy Options, each client has a primary care provider (PCP) who provides or arranges for all medical care 24 hours a day, seven days a week. Healthy Options is intended to:

- Offer high quality, comprehensive care with an increased emphasis on prevention.
- Increased access to appropriate medical services.
- Increased efficiency through medical case management and continuity of care.
- Enhance the health of Medical Assistance clients through health education, increased access to appropriate services and increased continuity of care.
- Reduce Medical Assistance administrative costs.
- Contain long term growth in medical care costs for Medical Assistance clients.
- Enable participating primary care providers to be reimbursed at more equitable levels than under fee-for-service.
- Reduce the risk of federal sanctions and/or lawsuits due to inadequate access.

The Healthy Options program reflects the State's desire to permit an array of service models for specific client populations or those in severely under served areas. As a result, it includes three managed care contracting models: full risk-based capitation through certified managed care plans, primary care case management (PCCM) with individual providers or clinics, and a modified primary care case management model through certified managed care plans. With full capitation, a health maintenance organization (HMO) or prepaid health plan (PHP) receives a monthly payment for each client to cover a wide range of services (see Appendix 1 for services included). With primary care case management, services are paid fee-for-service, but the primary care provider is also paid a small monthly case management fee for each client, while the third model is a blending of the other two. However, each model requires clients to obtain care from or through their primary care provider. Program savings are achieved through appropriate and efficient use of services, and the improved health status of clients.

Wisconsin

Medicaid Managed Care

PROGRAM NAME: Medicaid Managed Care

ORIGINAL IMPLEMENTATION DATE: August 1, 1984

CONTACT: Ruth Belshaw
Chief, Managed Care Section
(608) 266-1935

EXPIRATION DATE: August 29, 1996

GEOGRAPHIC AREAS: Dane, Eau Claire, Kenosha, Milwaukee and Waukesha Counties

NUMBER OF ENROLLEES: 137,804

FFS (PCCM) OR PRE-PAID OR BOTH: Prepaid

STATUTES WAIVED: 1903(m)(2)(A)(vi) - partial

POPULATION CATEGORIES INCLUDED: AFDC/Healthy Start, Healthy Start Pregnant Women

POPULATION CATEGORIES EXCLUDED: SSI Disabled, Elderly, SED Children

SERVICES INCLUDED: Inpatient Hospital, Laboratory, Rural Health Clinic, X-ray, Long Term Care, EPSDT, Family Planning, Physician, Home Health, FQHC Services, Dental, Pharmacy, Psychiatric, Chiropractic

FUTURE PLANS: Statewide expansion for this population beginning July, 1996, with HMO Enrollment expanded by 77,000 recipients by June, 1997.

Wisconsin Managed Care Program

Population: The primary HMO program is for recipients of AFDC and Healthy Start. The latter is Wisconsin's program for pregnant women and children whose family income is under 185% of the poverty level. Medicaid HMOs enroll approximately 40% of the AFDC and Healthy Start recipients state-wide. More than 140,000 recipients receive their medical care through an HMO in five participating counties: Milwaukee, Dane, Kenosha, Waukesha and Eau Claire.

Providers: In 1995, Wisconsin contracted with eleven HMOs for this program. To be eligible to participate, an HMO must be licensed by Wisconsin's Office of the Commissioner of Insurance. The HMO must also meet Medicaid's additional standards for quality assurance, cultural sensitivity, enrollment capacity and coordination of care.

Services: A single monthly payment for each enrollee (capitation payment) covers all Medicaid services except prenatal care coordination and common carrier transportation. If an HMO chooses not to cover dental and/or chiropractic services, the capitation rate is recalculated to exclude these services. Enrollees receive excluded services on a fee-for-service (FFS) basis.

Capitation: the capitation rates are established through a two-step process. First, an actuary determines for each participating county the FFS equivalent, an estimate of the per person per month cost to provide services on a FFS basis. Second, the HMOs bid a percentage of the FFS equivalent. By law, the state will pay no more than 90.5% of the FFS equivalent. When an HMO bids less than the maximum, it receives preference in the process to automatically assign those recipients who do not choose an HMO.

Savings: In 1995 the net savings totaled $20.6 million over cost of services and administration on a FFS basis. The savings is approximately 10% of the total cost of this HMO program.

Wisconsin

Primary Provider Program

PROGRAM NAME: Primary Provider Program; voluntary program for SSI beneficiaries	*ORIGINAL IMPLEMENTATION DATE:* November 1994
CONTACT: Angela Dombrowicki (608) 267-9474	*EXPIRATION DATE:* N/A
GEOGRAPHIC AREAS: Currently Milwaukee County	*NUMBER OF ENROLLEES:* as of 9/1/95: 10,055

FFS (PCCM) OR PRE-PAID OR BOTH: PCCM

STATUTES UTILIZED: 1993-95 State Budget (Wisconsin Act 16, Laws of 1993)

STATUTES WAIVED: 1915(b)

POPULATION CATEGORIES INCLUDED: SSI - Disabled

POPULATION CATEGORIES EXCLUDED: SSI-Disabled Nursing home - AFDC

SERVICES INCLUDED: All Medicaid covered services; Services that require authorization from PCP; Physician/Nurse Practitioner/Midwives; Inpatient/hospital; Outpatient/hospital; Surgical Service

PCP PROVIDER TYPES: Family/General Practice, Internists, Obstetricians, Gynecologists, Pediatricians, Nurse Practitioners - Midwives, Clinics, Federally Qualified Health Centers, Physician specialists on a case by case basis may also apply.

FUTURE PLANS: An expansion of voluntary PPP for SSI disabled population into 10 additional counties; Mandatory enrollment for AFDC/Healthy Start Recipients in areas of the state where HMO enrollment is not possible.

Wisconsin Primary Provider Program

A program is being implemented to facilitate Primary Provider coordination of medical care. This program was authorized by the Wisconsin Legislature in the 1993-95 State Budge (Wisconsin Act 16, Laws of 1993). The program will require recipients to obtain a referral from their Primary Provider prior to accessing physician or hospital services.

Services such as HealthCheck, personal care, therapies, transportation, community support programs, targeted case management, dental, chiropractic, podiatric, pharmacy, alcohol and drug abuse treatment, mental health and home health care will not require additional approvals beyond those already required in the Medicaid program.

Primary Care Physicians (Family Practitioners, General Practitioners, Internists, Obstetricians and Gynecologists, and Pediatricians) and Independent Nurse Practitioners could become Primary Providers. Clinics, Tribal Clinics, Federally Qualified Health Centers and Local Public Health Agencies could also become Primary Providers, if they have affiliated providers who could be individually certified as Primary Providers.

The Department will pay Primary Providers $3/month/patient to coordinate care for medical assistance (MA) recipients. A county-by-county staged implementation will begin Fall, 1994. The program will be voluntary for Primary Providers.

Program Goals

- The Primary Provider Program (PPP) is a partnership with providers giving them tools to direct and coordinate care.
- Development of a "medical home" for the MA recipients
- AFDC and Healthy Start recipients in Brown, Calumet, Fond du Lac, Manitowoc, Outagamie, Sheboygan, and Winnebago counties will be enrolled.
- In Milwaukee county, only non-institutionalized SSI disabled recipients under 65 years of age, who are not in any other managed care program will be enrolled.
- Program will be mandatory for recipients.

West Virginia

Physician Assured Access System

PROGRAM NAME: WV Physician Assured Access System	*ORIGINAL IMPLEMENTATION DATE:* June 1, 1992
CONTACT: Sue A. Thompson (304) 926-1707	*EXPIRATION DATE:* September 1, 1997
GEOGRAPHIC AREAS: Statewide	*NUMBER OF ENROLLEES:* 94,697

FFS (PCCM) OR PRE-PAID OR BOTH: FFS

STATUTES UTILIZED: 1915(b)

STATUTES WAIVED: 1902(a)(10)and 1902(a)(23)

POPULATION CATEGORIES INCLUDED: AFDC and AFDC related including women and children in groups created after 1988, SSI (voluntary)

POPULATION CATEGORIES EXCLUDED: Aged; Institutionalized and waiver recipient (e.g. Home and Community Based, TEFRA)

SERVICES INCLUDED: In and out patient hospital including ER; physician; lab and E-ray home health; OT, PT and speech and therapy; equipment and supplies

PCP PROVIDER TYPES: GP, FP: Pediatrics; ?M, Gyn's and Surgeons, if providers primary care; physician group practices; FQHC's and RHC's

FUTURE PLANS: Phase-out in counties with at least 2 participating HMOs

West Virginia Physician Assured Access System

The West Virginia Physician Assured Access System is a statewide managed care system operated by the Department of Health and Human Resources through the Bureau for Medical Services which provides recipients with a primary care provider who is responsible for providing or arranging the recipient's primary care and for referral for other medical services.

Individuals receiving medical assistance under the AFDC or AFDC related categories; women and children eligible under Federal expansion programs; and, as of June 1995 on a purely voluntary basis, recipients of SSI participate in the program and are identified by having the assigned provider listed by their name on the medical card. The aged population, SNF and ICF residents; and mental hospital patients are excluded from the program.

Participating physicians include general and family practitioners; pediatricians; obstetricians and gynecologists; internists; physicians practicing in primary care center, group practices or clinics; and Pediatric and Family Practice Nurse Practitioners.

Recipients are encouraged to select participating primary care providers practicing in their county of residence or a contiguous county. Recipients not selecting a primary care provider will be assigned one based on claims history when possible or within a thirty mile radius of their home.

Primary physicians, in addition to their normal FFS reimbursements from Medicaid, are paid a monthly fee of $3 for each patient they manage. They must arrange for physician coverage 24 hours per day, and the procedures to be followed when the office is closed. The provider's 24 hour access number is printed on the recipient's medical assistance identification card.

Obstetrical care, family planning services, routine eye care, chiropractic and podiatric care, outpatient mental health and pharmacy services may be provided for the recipient without referral from the primary physician.

Emergency care for specified diagnoses does not require authorization from the primary physician. Routine care in the emergency room is not payable under the program.

The PASS Advisory Committee functions as a subcommittee of the Medical Services Fund Advisory Council and advises the PAAS Program relative to issues and problems of access, quality of care, recipient/physician relationships, policies, procedures and reporting. It has representation from recipient advocacy groups, medical provider groups and health-related State agencies.

Wyoming

Selective Contracting for certain Inpatient Hospital Services

PROGRAM NAME: Selective Contracting for certain Inpatient Hospital Services

ORIGINAL IMPLEMENTATION DATE: January 1, 1994

CONTACT: Cheryl McVay (307)777-7245

EXPIRATION DATE: December 31, 1996

GEOGRAPHIC AREAS: Statewide

NUMBER OF ENROLLEES: 4116 (est.)

FFS (PCCM) OR PRE-PAID OR BOTH: FFS

STATUTES UTILIZED: 1915(b)(4)

STATUTES WAIVED: 1902(a)(23)

POPULATION CATEGORIES INCLUDED: All categories of children

SERVICES INCLUDED: neonatal intensive care; long-term psychiatric treatment; transplants

Wyoming Selective Contracting Hospital Program

The waiver allows Wyoming to develop a selective contracting program for hospital inpatient services for children. The waiver covers neonatal intensive care (NICU level III), psychiatric care (long term treatment of diagnosed disorders), and transplants (heart, liver, kidney, and bone marrow.)

The annual number of persons expected to receive services under the waiver is: neonatal intensive care - 1988; long term psychiatric services - 50; and transplant services - 12-20.

Costs of providing services under the waiver are based on negotiated rates and are lower than what costs would have been due to price competition, thus shifting utilization from high-cost providers to those with lower costs and higher quality.

Section 1115

Research and Demonstration Waivers

Arizona

Health Care Cost Containment System Demonstration Program

PROGRAM NAME: Arizona Health Care Cost Containment System (AHCCCS)	*ORIGINAL IMPLEMENTATION DATE:* October 1, 1982
CONTACT: Lynn Martinez (602) 417-4447	*EXPIRATION DATE:* September 30, 1997
GEOGRAPHIC AREAS: Statewide	*NUMBER OF ENROLLEES:* 428,845

FFS (PCCM) OR PRE-PAID OR BOTH: The vast majority of AHCCCS members are pre-paid; however, there is a small FFS window for person who are eligible but not yet enrolled in a Health Plan. AHCCCS also has approximately 50,000 American Indians who reside on-reservation and who are enrolled with the Indian Health Service (IHS) and receive FFS Medicaid services off-reservation that are not available through the IHS. Additionally, AHCCCS has 4,352 undocumented persons receiving emergency services on a FFS basis.

On August 1, 1995, AHCCCS began providing family planning services to women who lose SOBRA eligibility at 60 days postpartum. The extended services are provided FFS and are available for up to two years.

STATUTES UTILIZED: The authority for the current waiver is Section 1115 of the Social Security Act.

STATUTES WAIVED: See Attachment A for statutes waived.

POPULATION CATEGORIES INCLUDED:

- AFDC Cash and AFDC related
- SSI Cash and SSI related
- SOBRA pregnant women, infants and children born on or after September 30, 1983.
- Optional 1902(r)(2) children under the age of 14
- Persons with incomes up to 300% of SSI and eligible for the Arizona Long Term Care System

POPULATION CATEGORIES EXCLUDED: None of the mandatory groups

SERVICES INCLUDED: See Attachment B for services covered

PCP PROVIDER TYPES: Primary care physicians, nurse practitioners and physician assistants

FUTURE PLANS: Our future plans depend on whether there is Congressional action on Medicaid reform. Currently, AHCCCS is seeking HCFA approval to integrate services for persons who are dually eligible for Medicaid/Medicare.

AHCCCS Overview

The Arizona Health Care Cost Containment System (AHCCCS) is the single state Medicaid agency which administers Arizona's Medicaid Program as well as the state's indigent health care program for persons who do not qualify for Medicaid. As of June 30, 1995, AHCCCS provided acute care, behavioral health and long term care services to 428,845 Medicaid eligible members. Of that total, 408,484 members enrolled in the acute care program and 20,361 members are enrolled in the Arizona Long Term System (ALTCS).

The AHCCCS program is a statewide, managed care system based on prepaid capitated arrangements with Health Plans and long term care Program Contractors. It has operated under an 1115 Research and Demonstration Waiver since 1982 when the original waiver was granted by the Health Care Financing Administration. On October 1, 1995, AHCCCS began its fourteenth year of operation and has matured into a national model for the delivery of managed care. The Arizona Long Term Care System was fully implemented in January 1989 and delivers long term care and behavioral health services to persons who qualify based on financial and medical criteria.

The AHCCCS acute care program is based on preventive care rather than emergency care in emergency room settings. AHCCCS contracts with 14 private and public Health Plans who are a prospective, monthly capitation amount for each member enrolled with the Health Plan. Members are offered a choice of Health Plans in their county of residence and a choice of primary care practitioners within the Health Plan network. AHCCCS, in partnership with the Health Plans and primary care practitioners, is able to mainstream Medicaid recipients int the majority of private physician offices in the State. The primary care practitioners act as gatekeepers for the

system and managed all aspects of medical care for the members. AHCCCS delivers all mandatory Medicaid services and several optional services.

AHCCCS began providing long term care services to the developmentally disabled in December, 1988 and the elderly or physically disabled on January 1, 1989. Persons are eligible with income up to 300% of SSI and must pass a stringent preadmission screening all covered services: acute care, behavioral health, institutional services, home and community based services and case management, are integrated into a single delivery package. Services are coordinated and managed by eight Program Contractors who receive a prospective, monthly capitated payment which is blended to reflect the mix of institutional, home and community-based services, behavioral health services and case management. Only one Program Contractor operates in each county and members are enrolled with the Program Contractor in their county of residence. Once enrolled, the member has a choice of available primary care physicians/practitioners who coordinate care and act as gatekeepers.

Improved quality management is a major initiative for AHCCCS. Using federal requirements as a basis, AHCCCS expanded quality management functions and tailored the quality management program to fit a managed care environment in both the acute care and ALTCS programs. AHCCCS is developing a member survey designed to evaluate the performance of Health Plans and Program Contractors and will use encounter data to measure quality indicators.

AHCCCS has been evaluated by several outside entities, including the United States General Accounting Office and an independent HCFA contractor. The conclusions have been that AHCCCS does save money when compared with traditional fee-for-service programs and does not sacrifice quality of care.

AHCCCS WAIVERS

- Section 1902(a)(20(A), (42 CFR 435.211)
- Section 1902(a)(50), Section 1902(q)(1)(A), (42 CFR 435.735)
- Section 1902(a)(14), (42 CFR 447.50 and 447.53)
- Section 1902(a)(10)(B)(1), Insofar as its requirements preclude the imposition of a copayment on services for any categorically needy individuals, where other categorically needed individuals have been exempted from the copayment for receiving the same services when the service is furnished as "well baby" care (42 CFR 440.240)
- Section 1902(a)(23), (42 CFR 431.51)
- Section 1902(a)(13), (42 CFR 447.250 - 447.371 (except for 447.253(b)(1)(I), in order that the reasonable and adequate payment

requirements of the Boren Amendment are not waived)" Section 1902(a)(30), insofar as it is implemented by the regulations cited above; Section 1902(a)(4), insofar as it is implemented by 42 CFR 434.23

- Section 1902(a)(10)(A)(ll)(V), (42 CFR 435.217 and 435.236)
- Section 1902(a)(54), (42 CFR 456.700 - 456.725)
- Section 1902(a)(10)(B), (42 CFR 440.240)
- Section 1902(a)(10)(A)(ii)
- Section 1902(a)(17), Section 1902(q)(1)(A), (42 CFR 435.725 and 435.726)

Under the authority of section 1115(a)(2) of the SSA, expenditures made by the State for the items identified below (which are not otherwise included as expenditures under section 1903) shall, for the period of this project, be regarded as expenditures under the States's title XIX plan:

- Expenditures to provide Medicaid to individuals who would be otherwise excluded by virtue of section 1903(I)(3) or section 1903(m)[except for subsections (iii), (iv), (v), (vii), (x), and (xi) of section 1903(m)(2)(A)].

- Expenditures associated with provision of HCBS services to individuals determined to be eligible and for services specified in the program and within the limit placed on the program

- Expenditures to provide Medicaid to individuals who have been guaranteed 6 months of Medicaid eligibility at the time they are enrolled in a capitated health plan under AHCCCS, who were eligible for Medicaid when they enrolled, and who ceased to be eligible during the 6-month period.

- To enable the State to restrict beneficiaries to AHCCCS contract providers.

- Expenditures for outpatient drugs which would otherwise be excluded by virtue of section 1903(I)(10).

- Expenditures to extend ALTCS eligibility to children under the age of 18 using the preadmission screening instrument as a substitute eligibility standard.

- Expenditures to provide continued medical coverage to children who meet the initial eligibility requirement as a deemed newborn without consideration of the mother's continued Medicaid eligibility.

- Expenditures to provide family planning services for up to 24 months to AHCCCS eligible women who subsequently lose eligibility at 60 days post partum.

ACUTE CARE SERVICES

Covered Acute Care services are:

- Inpatient and outpatient hospital
- Emergency room
- Physician
- Outpatient Health Services, including those services that may be provided in a Rural Health Clinic or Federally Qualified Health Center
- Laboratory, X-Ray and medical imaging
- Pharmacy
- Medical supplies, durable medical equipment and prosthetic devices
- Emergency ambulance transportation
- Medically necessary transportation
- Family Planning, including drugs, supplies, devices and surgical procedures provided to delay or prevent pregnancy
- Abortion, in cases of rape or incest or to save the life of the mother
- Therapies which include, physical, occupational, respiratory, audiology and speech therapies
- Podiatry
- Private duty nursing, if medically necessary
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT.) services for members under the age of 21. Behavioral health services are limited to 72 hour emergency care for state-funded children
- Cornea, autologous and allogenic bone marrow transplantations with related chemotherapy and/or radiotherapy, liver, kidney, heart, lung and heart/lung transplantations, with related

immunosuppressant medications, are covered by AHCCCS for all members.

- Eyeglasses and contact lenses for members 21 years and older as the sole external prosthetic device after a cataract extraction.
- Emergency dental care, extractions and medically necessary dentures for members 21 years and older.
- Home health services in lieu of hospitalization.
- Nursing facility services in lieu of hospitalization
- Nursing facility services in lieu of hospitalization not to exceed 90 days.

Acute Care Behavioral Health Services

- Inpatient hospital
- Inpatient psychiatric facility for individuals under the age of 21
- Individual therapy and counseling
- Group and/or family therapy counseling
- Psychotropic medication adjustment and monitoring
- Partial care (basic and intensive)
- Emergency crisis behavioral health care
- Behavior management
- Psychosocial rehabilitation
- Screening
- Evaluation and diagnosis
- Case Management (SMI Clinical and Children's Intensive)
- Psychotropic medications
- Laboratory and radiology services for psychotropic medication diagnosis and regulation

ALTCS SERVICES

Covered ALTCS services include the previously identified acure care services and:

- Nursing Facility, including Christian Science Sanitoria and nursing
- Hospice
- Adult Day Health (EPD only)
- Intermediate Care Facility for Mentally Retarded (DD only)
- Developmentally Disabled Day Care (DD only)
- Home Delivered Meals (EPD only)
- Home Health Agency services, including nursing services and home health aid

- Homemaker
- Personal Care
- Respite Care
- Habilitation (DD only) and Habilitation type services for EPD
- Group Respite as an alternative to Adult Day Health (EPD only)
- Attendant Care (EPD only)
- Attendant Car (DD only)
- Environmental Modifications
- Life Line Alert (DD only)
- Supported Employment for DD ALTCS Transitional
- Other services, if approved by HCFA and the Director of AHCCCS

ALTCS Behavioral Health Services

- Inpatient hospital
- Inpatient Psychiatric Facility for members under 21 years
- Institution for Mental Diseases for members 65 years and older
- Individual therapy and counseling
- Group and/or family therapy and counseling
- Emergency crisis mental health care
- Evaluation and diagnosis
- Screening (DD only)
- Psychotropic medications
- Intensive partial care (DD only)

California

Center for Elders Independence Demonstration Project

PROGRAM NAME:
Center for Elders Independence (CEI)

ORIGINAL EFFECTIVE DATE:
July 1, 1995

CONTACT: Joseph A. Kelly, Chief
Medi-Cal Managed Care Division
714 P Street, Room 650
Sacramento, CA 95814
916-654-8076

EXPIRATION DATE:
June 30, 1998

NUMBER OF ENROLLEES: 118

GEOGRAPHIC AREAS: Alameda County

FFS (PCCM) OR PRE-PAID OR BOTH: Prepaid HMO

STATUTES UTILIZED: 1115

STATUTES WAIVED: 1902(a)(1), 1902(a)(23), 1903(m)(2)(a), 1903(f)(4)(C)

POPULATION CATEGORIES INCLUDED: Public Assistance Aged (Old Age Survivor, Public Assistance); Medically Needy Aged (Old Age Survivor, Medically Needy), Public Assistance Blind (Aid to the Blind, Public Assistance); Medically Needy Blind (Aid to the Blind, Medically Needy); Public Assistance Disabled (Aid to the Totally Disabled, Public Assistance); Medically Needy Disabled (Aid to the Totally Disabled, Medically Needy); Medically Indigent Adult (Medically Indigent); and Refugees, Entrants (Aged, Blind). **All other populations are excluded.**

SERVICES INCLUDED: Full scope of Medi-Cal benefits

PCP PROVIDER TYPES: Multi-disciplinary approach which includes: Physicians, nurses, dentists, occupational physical recreational therapists, pharmacists, home health aids, etc.

FUTURE PLANS: Expanding to another site effective December 1995

California Care for Elderly Independence

CEI is a Program of All-Inclusive Care for the Elderly (PACE) replication of the On Lok Model. CEI provides health and social services to participants who are eligible for Medicaid and Medicare, 55 years or older, live in a specific geographic area and certified by the State of California for nursing home level of care. CEI's multi disciplinary team tailors an individualized treatment plan and provides the care directly to the participant. Services include: primary medical care; inpatient hospital, nursing, occupational, physical and recreational therapies, personal care, transportation, recreational and cultural activities.

California

Scan Health Plan Demonstration Project

PROGRAM NAME:
SCAN Health Plan, a Social Health Maintenance Organization

ORIGINAL EFFECTIVE DATE:
January 1,1985

CONTACT: Joseph A. Kelly, Chief
Medi-Cal Managed Care Division
714 P Street, Room 650
Sacramento, CA 95814
916-654-8076

EXPIRATION DATE: 8/31/96

NUMBER OF ENROLLEES: 549

GEOGRAPHIC AREAS: Parts of Los Angeles County

FFS (PCCM) OR PRE-PAID OR BOTH: Prepaid Social HMO

STATUTES UTILIZED: 1115

STATUTES WAIVED: 1902(a)(1), 1902(a)(10), 1902(a)(23), 1902(e)(30), 1902(e)(2)(A)

POPULATION CATEGORIES INCLUDED: Public Assistance/Old Age Survivor, Public Assistance/Aid To the Totally Disabled/Aid to the Blind, Medically Needed/Old Age Survivor, Medically Needed/Aid To the Totally Disabled/Aid to the Blind, Medically Needed/Long Term Care/Old Age Survivor, Medically Needed/Aid To the Totally Disabled/Aged, Blind, and Disabled.

POPULATION CATEGORIES EXCLUDED: All others

SERVICES INCLUDED: Full scope of Medi-Cal benefits

PCP PROVIDER TYPES: Independent Practice Associations and/or Medical Groups

FUTURE PLANS: Increase enrollment in southern part of State

California Scan Health Plan Demonstration Project

In the spring of 1980, the Office of Research and Demonstrations awarded a 3-year planning grant to the University Health Policy Consortium (UHPC) at Brandeis University to develop the conceptual design for the Social Health Maintenance Organization (SHMO) demonstration. A SHMO is a managed system for the provision of health and long term care services. Under this model, a single entity assumes case management responsibility for a full range of acute inpatient, ambulatory, rehabilitative, extended care, home health, and personal care services, which are to be provided within a prospectively determined fixed budget. The SHMO operating principles are similar to those of a regular health maintenance organization. Specifically, elderly persons who reside in the target service area are voluntarily enrolled through the marketing efforts of the SHMO. Once enrolled, they are obligated to receive all covered services through SHMO providers.

The operational status of the project was assured by congressional mandate (P.L.98-369, "The Deficit Reduction Act of 1987") in July 1984. The legislation mandated the Secretary to approve the protocols for the four SHMO sites and provide for an evaluation of the demonstration. Subsequent legislation (P.L. 100-203, "The Omnibus Budget Reconciliation Act 1987") enable the demonstration to continue through September 1992. The Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508), extended continuation of the SHMO demonstration through December 1995, with the Report to Congress due no later than March 31, 1996. SCAN Health Plan became operational on March 1, 1985.

The SHMO benefit package includes the standard Medicare benefit package (with removal of copays and deductibles, and extension of benefit days/period), plus additional long term care and other supplemental benefits. The long term care benefit package includes additional nursing facility care; medical transportation, in-home support services (such as homemaker, home health aide, adult day care, medical transportation, in-home respite care, electronic monitoring); and case management of service delivery need. Supplemental services include prescription drugs, optometric services, and hearing care services.

California

On Lok Senior Health Services Demonstration Project

PROGRAM NAME:
On Lok Senior Health Services

ORIGINAL EFFECTIVE DATE: 7/1/83

EXPIRATION DATE: 6/30/96

CONTACT: Joseph A. Kelly
916-654-8076

NUMBER OF ENROLLEES: 430

GEOGRAPHIC AREAS: San Francisco County

FFS (PCCM) OR PRE-PAID OR BOTH: Prepaid HMO

STATUTES UTILIZED: 1115

STATUTES WAIVED: 1902(a), 1902(a)(10), 1902(a)(23), 1903(m)(2)(A), 1903(f)(4)(C)

POPULATION CATEGORIES INCLUDED: Public Assistance Aged (Old Age Survivor, Public Assistance); Medically Needy Aged (Old Age Survivor, Medically Needy), Public Assistance Blind (Aid to the Blind, Public Assistance); Medically Needy Blind (Aid to the Blind, Medically Needy); Public Assistance Disabled (Aid to the Totally Disabled, Public Assistance); Medically Needy Disabled (Aid to the Totally Disabled, Medically Needy); Medically Indigent Adult (Medically Indigent); and Refugees, Entrants (Aged, Blind).

POPULATION CATEGORIES EXCLUDED: All Others

SERVICES INCLUDED: Full scope of Medi-Cal Benefits

PCP PROVIDER TYPES: Multi-disciplinary Team approach which includes: Physicians, nurses, dentists, occupational, physical, recreational therapists, pharmacists, home health aids, and social workers

FUTURE PLANS: An additional site is expected in 1996.

California On Lok Senior Health Services Demonstration

On Lok's program provides health and social services to participants who are eligible for Medicaid and Medicare, 55 years or older, live in a specific geographic area and are certified by the State of California for nursing home level of care. On Lok's multi-disciplinary team tailors an individualized treatment plan and provides the care directly to the participant. Services include: primary care; inpatient hospital; nursing; occupational physical and recreational therapies; personal care, transportation, recreational and cultural activities.

California

Sutter Senior Care Demonstration Project

PROGRAM NAME:
Sutter Senior Care

ORIGINAL EFFECTIVE DATE:
January 1, 1995

CONTACT: Joseph A. Kelly
916-654-8076

EXPIRATION DATE: March 31, 1995

GEOGRAPHIC AREAS: Sacramento County *NUMBER OF ENROLLEES:* 145

FFS (PCCM) OR PRE-PAID OR BOTH: Prepaid HMO

STATUTES UTILIZED: 1115

STATUTES WAIVED: 1902(a)(1), 1902(a)(10), 1902(a)(23), 1903(m)(2)(A), 1903(f)(4)(C)

POPULATION CATEGORIES INCLUDED: Public Assistance Aged (Old Age Survivor, Public Assistance); Medically Needy Aged (Old Age Survivor, Medically Needy), Public Assistance Blind (Aid to the Blind, Public Assistance); Medically Needy Blind (Aid to the Blind, Medically Needy); Public Assistance Disabled (Aid to the Totally Disabled, Public Assistance); Medically Needy Disabled (Aid to the Totally Disabled, Medically Needy); Medically Indigent Adult (Medically Indigent); and Refugees, Entrants (Aged, Blind).

POPULATION CATEGORIES EXCLUDED: All others

SERVICES INCLUDED: Full scope of Medi-Cal benefits

PCP PROVIDER TYPES: Multi-disciplinary team approach which includes: physicians, nurses, dentists, therapists, social workers

FUTURE PLANS: The Program will increase enrollment of expansion site that opened April 1995.

California Sutter Senior Care Demonstration Project

Sutter Senior Care is a Program of All-Inclusive Care for the Elderly (PACE) replication of the On Lok Model. Sutter Senior Care provides health and social services to participants who are eligible for Medicaid and Medicare, 55 years or older, live in a specific geographic area, and are certified by the State of California for nursing home level of care. Sutter's multi-disciplinary team tailors an individualized treatment plan and provides the care directly to the participant. Services include: primary care, inpatient hospital, nursing, occupational, physical and recreational therapies, personal care, transportation, recreational, and cultural activities.

Florida

Resource Mothers Demonstration Program

PROGRAM NAME:	*ORIGINAL IMPLEMENTATION DATE:*
"Resource Mothers" Research and Demonstration	February 10,1991
CONTACT:	*EXPIRATION DATE:*
Reid Jaffe (904) 488-1949	May 31, 1997
GEOGRAPHIC AREAS:	*NUMBER OF ENROLLEES:*
North Central Florida	107

FFS (PCCM) OR PRE-PAID OR BOTH: FFS

STATUTES UTILIZED: 1115(a)

STATUTES WAIVED: 1902 (a)(10)(b), 1902 (a)(1)

POPULATION CATEGORIES INCLUDED: Women at risk of having low birthweight babies

POPULATION CATEGORIES EXCLUDED: all others

SERVICES INCLUDED: "special demonstration services"

PCP PROVIDER TYPES: N/A

FUTURE PLANS: end project at expiration date

Resource Mothers

The formal name for this project is "Program of Preconceptional Intervention for Women at Risk for Low Birth Weight Infants." It is funded under Cooperative Agreement 11-C-90154.

The project is an evaluation of an intervention that is designed to reduce infant mortality and reduce health care costs through improved reproductive health. the strategy employed is a multi-disciplinary preconceptional intervention involving risk identification and reduction. The intervention attempts to improve maternal health and well being with the expectation that this will result in better reproductive outcomes. The primary service provider is a paraprofessional who works with clients in their homes. the target group is low income women who are at high risk for poor pregnancy outcome in a subsequent pregnancy. This intervention is based on the following assumptions:

1. certain maternal factors such as smoking, poor nutritional status, stress and lack of employment contribute to poor reproductive outcomes;

2. many of these factors can be changed by the women herself;

3. changing the factors will result in improved pregnancy outcomes;

4. the intervention can promote change in these factors among the participants; and

5.the change will result in a measurable improvement in pregnancy related outcomes.

Goals and Objectives

A basic assumption is that reduced risks occurring during intervention will result in improved outcomes. Thus, the goal of the intervention is to reduce infant mortality by improving pregnancy outcomes. The objectives of the intervention are promotion of activities that will result in improved maternal physical and mental health.

The goal of the research is to determine if the intervention offered to the service group results in improved reproductive health, specifically, reduced rates of unwanted pregnancy and low birthweight. If the intervention has the desired impact, the research analysis will demonstrate what cost saving resulted and if they are greater than the cost of the program.

Hawaii

Quest Demonstration Project

PROGRAM NAME: Hawaii Quest *ORIGINAL IMPLEMENTATION DATE:* August 1, 1994

CONTACT: Winifred Odo (808) 588-5391 *EXPIRATION DATE:* July 1999

GEOGRAPHIC AREAS: Statewide

FFS (PCCM) OR PRE-PAID OR BOTH: Pre-paid Managed Care

STATUTES UTILIZED: Section 1115, Social Security Act

STATUTES WAIVED: Amount, Duration and Scope of Service - Section 1902(a)(10)(B) Uniformity - Section 1902(a)(1), Eligibility - Section 1902(a)(10)(A)(I)(l), (lll) - (Vll); Section 1902(a)(52); Section 1902(e)(1)(A); Section 1902(e)(4)-(7); Section 1902(a)(25)(G); Section 1902(a)(34); Section 1902(a)(51)(A); Section 1902(a)(58); Section 1902(a)(10)(C)(ll); Section 1902(a)(17)(D),Quality Review of Eligibility - Section 1902(a)(4), Freedom of Choice - 1902(a)(23), Upper Payments Limits for Capitation Contract - Section 1902(a)(30), Payment of Federally Qualified Health Centers - Section 1902(a)(10), Payment of Rural Health Clinics - Section 1902(a)(13)(E), Premium Payments - Section 1902(a)(14), Disproportionate Share Hospital Payments - Section 1902(a)(13), Section 1903(m)(1)(A) and (2)(A), Section 1903(f)

POPULATION CATEGORIES INCLUDED: AFDC; Subsidized Adoption Children; Foster Children, General Assistance, All Children and Families with Income under 300% of FPL

POPULATION CATEGORIES EXCLUDED: Aged, Blind and Disabled

SERVICES INCLUDED: ALL mandatory services and the following optional services:

- o Prescription Drug
- o Dental
- o Vision
- o PT

- o OT
- o Speech, Hearing, Language Disorders
- o Prosthetic Devices
- o Preventive Services
- o Screening Services
- o Rehabilitative Services
- o Emergency Hospital Services
- o Transportation Services
- o Case Management Services
- o Hospice Care
- o Respiratory Care

PCP PROVIDER TYPES: Family Practitioners, Internists, Pediatricians, OB-GYNs for pregnant women

FUTURE PLANS: Integrate the ABD categories into a managed care program

Hawaii QUEST

o Hawaii QUEST is a five-year demonstration project implemented on August 1, 1994 under a Section 1115 from the Health Care Financing Administration (HCFA)

o Initial enrollment included about 105,000 individuals who had previously been covered by Aid to Families with Dependent Children (AFDC), the State Health Insurance Program (SHIP) or General Assistance (GA)

o New applications were accepted beginning August 1, 1994. Current enrollment stands at about 150,000

o QUEST is a managed care program which "privatizes" public health care. Five private health insurance plans -- AlohaCare, HMSA, Kaiser, Queen's Hawaii Care and StraubCare Quantum - and two private dental plans--DentiCare and HMSA dental--provide care under QUEST.

o Participants in QUEST have an opportunity to choose their health and dental plans, as well as the Primary Care Provider (PCP) and Primary Care Dentist (PCD) who will provide the majority of their health care. Those who do not choose their plans are auto-assigned to plans based on an algorithm developed by

the State. Those who do not choose their PCP and/or PCD are assigned by their plan to a provider in their area.

o QUEST excludes those who are age 65 and over or who are certified blind or disabled. Eligible individuals in these groups are covered by Medicaid on fee-for-service basis. It is anticipated that eventually these groups will be merged into the QUEST program. The final determinations on this have not been made as of this date.

o QUEST offers a comprehensive benefit package, providing coverage for most physical and behavioral health problems. The State has also developed a "wraparound" behavioral health program to provide care for those participants determined to be seriously mental ill (SMI) and in need of long-term or extensive mental health care.

o Currently, those with a gross monthly family income of up to 300% of the current Federal Poverty Level (HPL) are financially eligible to apply for QUEST. With some exceptions, those who income in between 100% and 300% of the FPL must pay a share of the monthly premium for their coverage. Those who are self-employed will pay a minimum premium share. Premium share is determined on a sliding scale based on income.

o With some exceptions, those with incomes between 100% and 300% of the FPL are required to pay small copayments for some services. For example, there is a $5 copayment per doctor's visit, a $2 copayment for generic drugs and a $5 copayment for brand-name multisource drugs, and $25 copayment per hospital admission.

o In October, 1994, the State awarded the contract to provide catastrophic reinsurance for QUEST to Anthem Life Insurance Company and its sister companies, AdminiaStar Solutions and Acordia Petit-Morry. Reinsurance will apply when a given QUEST recipient's medical expenses exceed $30,000.

o In November, 1994, the State awarded the contract for development of the QUEST Information System (QIS) to the Unisys Corporation. The system is expected to be operational in 1996.

Maryland

Maryland Kids Count Demonstration Project

PROGRAM NAME: Maryland Kids

ORIGINAL IMPLEMENTATION DATE: October 1, 1993

CONTACT: Susan Tucker
(410) 225-6538

EXPIRATION DATE: August 31, 1998

GEOGRAPHIC AREAS: Statewide

NUMBER OF ENROLLEES: 4,210

FFS (PCCM) OR PRE-PAID OR BOTH: FFS

STATUTES UTILIZED: 1115(a)(2)

STATUTES WAIVED: 1902(a)(10)(A), 1902(a)(10)(B), 1902(a)(17), 1902(a)(43)(A)

POPULATION CATEGORIES INCLUDED: Children born after 9/30/93, at least age 1, not eligible for Medicaid, and family income does not exceed 185% of poverty.

SERVICES INCLUDED: Preventive pediatric care, EPSDT screening services

Maryland Kids Count Program

The Maryland Medical Assistance Program received federal approval of its 1115 waiver request to establish a Demonstration Project for Preventive and Primary Pediatric Care. This program, which is known as Maryland Kids Count, began on October 1, 1993. It provides a package of primary and preventive services for children who are not currently eligible for Medical Assistance because their family income is too high. The Department of Health and Mental Hygiene estimates that 15,000 uninsured children will be eligible for Maryland Kids Count.

The benefits offered under this Program include the following: well child visits, immunizations, screening for lead poisoning and other conditions, sick care in physician offices and clinics, diagnostic tests, vision care and eyeglasses, health-related special education services delivered in the schools, and prescription drugs with a co-payment of $5 per prescription. Dental services, as well as hospital inpatient, outpatient, and emergency room services are not covered.

Maryland

Family Planning Waiver Demonstration Project

PROGRAM NAME: Family Planning Waiver	*ORIGINAL IMPLEMENTATION DATE:* December 1, 1994
CONTACT: Susan Tucker (410) 225-6538	*EXPIRATION* DATE: November 31, 2000
GEOGRAPHIC AREAS: Statewide	*NUMBER OF ENROLLEES:* 6,494

FFS (PCCM) OR PRE-PAID OR BOTH: FFS (PCCM)

STATUTES UTILIZED: 1115(a)(2)

STATUTES WAIVED: 1902(a)(10)(A), 1902(a)(10)(B), 1902(a)(17), 1903(f)

POPULATION CATEGORIES INCLUDED: Pregnant Women who remain eligible for 60 day post partum, not otherwise eligible for Medicaid and whose income is at or below 185% of federal poverty level

SERVICES INCLUDED: Outpatient family planning, family planning pharmacy services, professional fees for surgical family planning, screening for sexually transmitted diseases, testing and counseling for HIV and colposcopy services.

PCP PROVIDER TYPES: Physicians, Certified Mis-Wives, Nurse Practitioners, Free Standing Clinics and Hospital Clinics

Maryland Family Planning

The Maryland Family Planning and Preventive Reproduction Services is a program to limit Medicaid eligibility and provide family planning and related services to women in the Pregnant Women and Children (PWC) Medicaid eligibility category who lose Medicaid coverage after their pregnancy related period of eligibility. Normally, the period of Medicaid eligibility ends two months after delivery, but this waiver extends the eligibility for five years during which family planning and related preventive reproductive services are available. With this demonstration, Maryland will evaluate whether providing this coverage will increase continuity of reproductive care; increase the use of family planning services among low income women; reduce unintended pregnancies; increase opportunities for screening, and reduce costs to the Medicaid program.

Women are notified as they sign for the PWC Program of this option and are given a pamphlet describing the services. Only women who lose PWC coverage are eligible. Women who are only presumptively eligible do not qualify. If they choose to enroll, they receive a special care explaining the benefits of the program. They are informed of a hotline that provides referrals to family planning providers or offers additional information on benefits and eligibility for other services. A participant remains eligible as long as she is not eligible for another Medical Assistance Program or moves out of state during the five year period.

Outreach is conducted with existing programs and local health and nursing directors to encourage use of these services. Medicaid providers are informed via standard transmittal procedures.

Minnesota

Prepaid Medical Assistance Waiver Plus Demonstration Project

PROGRAM NAME:
Prepaid Medical Assistance
Waiver Plus PMAP
(MinnesotaCare Health Care Reform Waiver)

ORIGINAL IMPLEMENTATION DATE:
July 1, 1985

CONTACT: Ann Berg
(612) 296-0642

EXPIRATION DATE: June 30, 1998

GEOGRAPHIC AREAS:
For eligibility purposes, the waiver will be in effect statewide. For managed care, the current geographic areas are the original PMAP counties (Dakota, Hennepin, Itasca), plus Ramsey, Anoka, Carver, Scott, Washington, Benton, Sherburne, Stearns, Carlton, Cook, Koochiching, Lake, and St. Louis counties.

NUMBER OF ENROLLEES: As of October 1, 1995, MinnesotaCare active ability was 90,230. For managed care, the enrollment as of September 30, 1995 was 160,000.

FFS (PCCM) OR PRE-PAID OR BOTH: Fee for service and prepaid.

STATUTES UTILIZED: 1115(a)(1) Authority
STATUTES WAIVED:

- Section 1902(a)(1) of 42 CFR 431.50 and 434.25(a)(2)
- Section 1902(a)(10) paragraph VII in the matter after 1902(a)(10) (F)
- Section 1902(a)(23) of the SSA and 42 CFR 431.51
- Section 1902(a)(30) as implemented by 42 CFR 447.361
- Section 1902(a)(4) as implemented by 42 CFR 434.23
- Section 1902(a)(10) of the SSA and 42 CFR 440.240(b)
- Section 1902(a)(13)(E)
- Section 1902(a)(4)(A)
- Section 1902(a)(7) and 42 CFR 431.306

POPULATION CATEGORIES INCLUDED: ALL MA and Minnesota Care eligibles except the following list of those excluded.

POPULATION CATEGORIES EXCLUDED:

- MA eligible person through spenddown
- lives in a state institution
- receives benefits under the Refugee Assistance Program
- is MA eligible through an adoption subsidy
- is under age 65 and is blind or is certified disabled using SSI criteria
- currently has private HMO coverage, and chooses not to enroll
- is a resident of Itasca County living near the county border using Cass, Lake, Hibbing or Red Lake providers
- is a Qualified Medicare Beneficiary and not otherwise MA eligible
- is a foster placement
- is a child in need of protective services
- is a child diagnosed as SED, is receiving county MH case management and is receiving primary MH services prior to enrollment in PMAP
- has a communicable disease for which the prognosis is terminal and whose primary physician certifies that disruption of the physician-patient relationship would be harmful

SERVICES INCLUDED: All state plan mandated services excluding nursing homes and ICFMR's.

PCP PROVIDER TYPES: Contracts are with licensed HMOs except for IM Care.

FUTURE PLANS: Eligibility will be statewide under the waiver and managed care will expand into more counties.

Minnesota Prepaid Medical Assistance Plus

This waiver is an extension of Minnesota's Prepaid Medical Assistance, 1115 waiver which has been approved since 1985, and adds new eligibility and managed care components. The waiver encompasses two phases of reform. The goal of Phase 1 is to expand both the Medical Assistance (MA) and Prepaid Medical Assistance Program (PMAP). The goal of Phase 2 is to simplify and integrate MA, general assistance medical care (GAMC), and MinnesotaCare, and to provide linkage to state health care reform. The components of phase 1 are as follows:

- Expansion of PMAP (managed care) including statewide managed care for MinnesotaCare enrollees;
- One month rolling eligibility for managed care enrollees;
- Pregnant women and children under age 21 in MinnesotaCare will be entitled to the same benefits they could otherwise obtain under Medicaid, and are exempt from copayments and the required disenrollment for nonpayment of a premium;
- Automatic MA coverage to any child born to a mother on MA will extend to age two provided that the mother was eligible for and receiving MA at the time of the birth and child remains in the household;
- Cooperation in establishing paternity and medical support;
- Retroactive FFP for persons covered under the state funded GAMC who were Medicaid eligible;
- Expand managed care in Itasca County to include those who are disabled.

Phase 2 of the waiver will continue to be developed with the cooperation of HCFA.

Oregon

Oregon Health Plan Demonstration Project

PROGRAM NAME:	*ORIGINAL IMPLEMENTATION DATE:*
Oregon Health Plan (OHP) Medicaid Demonstration Project	February 1, 1994
CONTACT:	*EXPIRATION DATE:*
Joel Young, Acting Manager Program and Policy Unit Office of Medical Assistance Programs (503) 945-6494	December 31, 1998
GEOGRAPHIC AREAS:	*NUMBER OF ENROLLEES:*
State of Oregon	385,544 OHP eligibles 298,304 enrolled in managed care

*FFS (PCCM) OR PRE-PAID OR BOTH:*Both

STATUTES UTILIZED: 1115 Waiver

STATUTES WAIVED:
Section 1902(a)(10)(B);42 CFR 440.230-250
Section 1902(a)(1);42 CFR 431.50
Section 1902(a)(10)(C); 42 CFR 435.301, 435.811, 435.845, 435.850-52 and 440.220
Section 1902(a)(17); 42 CFR 435.100 and 42 CFR 435.602-823
Section 1902(a)(10)(A) and Section 1902(a)(34); 42 CFR 435.401 and 435.914
Section 1902(a)(23); 42 CFR 431.51
Section 1902(a)(30); 42 CFR 447.361
Section 1902(a)(10) and Section 1902(a)(13)(E)
Section 1902(a)(43)(A)
Section 1902(a)(13)(A)

POPULATION CATEGORIES INCLUDED:
Aid to Dependent Children (ADC); Poverty Level Medical-Women (PLM-W); Poverty Level Medical-Children (PLM-C) (up to 133% federal poverty level); General Assistance (GA); OHP only (under 100% federal poverty level): Aged, Blind and Disabled; Foster Care Children

POPULATION CATEGORIES EXCLUDED: Qualified Medicare Beneficiaries (QMB) and Medically Needy Population

SERVICES INCLUDED: Condition/treatment pairs subject to funding based on position on the Prioritized List of Health Services; other services necessary to meet the client's needs.

PCP PROVIDER TYPES: Physician (MD or DO), nurse practitioner, physician assistant, naturopathic physician

FUTURE PLANS: Oregon will be considering whether or not to initiate a competitive bidding process for health plan contractors.

Oregon Health Plan

The Oregon Health Plan is a blueprint for universal access to basic and affordable health coverage. The 1115 Waiver is to be seen in the context of larger health care reform including reforms to make insurance more affordable, small employer plans, coverage for individuals denied coverage for other reasons, and other efforts to provide basic health care for low income persons.

The key elements of the Oregon Health Plan Medicaid Demonstration include:

- Expansion of eligibility to 100% of FPL.
- Prioritized list of benefits, including integration of mental health services on a phase-in basis.
- Total state-wide managed care delivery systems almost entirely consisting of fully capitated health plans.
- Reasonable cost based capitation methodology.
- Participation of all federally qualified HMOs in Oregon, as well as other Medicaid only fully capitated health plans.
- Non-competitive process for contracting.
- Inclusion of all of the Medicaid eligible population in Oregon. Special modifications to support the inclusion of vulnerable populations including exceptional needs care coordination (capitated), care coordination referral process, and appropriate quality assurance measures at state and plan level.
- Reasonable cost reimbursement model for managed care plans.
- Use and collection of encounter data.
- Testing integrated and carve-out mental health managed care models.
- Testing physical medicine cost offset from inclusion of chemical dependency outpatient in fully capitated health plan contracts.

Rhode Island

Rite Care Demonstration Project

PROGRAM NAME:	*ORIGINAL IMPLEMENTATION DATE:*
Rite Care - 1115 Demonstration	April 1, 1994
CONTACT:	*EXPIRATION DATE:*
Tricia Leddy (401) 464-3113	March 31, 1999
GEOGRAPHIC AREAS: Statewide	*NUMBER OF ENROLLEES* 65,000

FFS (PCCM) OR PRE-PAID OR BOTH: Pre-paid capitation

STATUTES UTILIZED: Section 1115(a)(1) and (2) of the Social Security Act

STATUTES WAIVED: The following sections of the Social Security Act are waived: 1902(a)(10)(B); 1902(a)(1); 1902(a)(10)(A)(ii)(I) and (II); 1902(a)(17)(D); 1902(a)(23); 1902(a)(30); 1902(a)(13)(E); 1902(a)(34); 1902(a)(14)

POPULATION CATEGORIES INCLUDED: All AFDC recipients and pregnant women and children under age 6 whose income is below 250% of the Federal Poverty Level

POPULATION CATEGORIES EXCLUDED: All aged, blind and disabled and related coverage groups and all medically needy groups

SERVICES INCLUDED: Inpatient and outpatient hospital services; physician services; dental services; family planning services; prescription drugs; laboratory services; radiology and other diagnostic services; certain mental health and substance abuse treatment services; preventive care, EPSDT services and enhanced services (i.e. outreach services, home visits, smoking cessation, childbirth education classes, parenting classes, nutrition services, transportation and interpreter services)

PCP PROVIDER TYPES: 4 HMOs and an FQHC based HMO

FUTURE PLANS: State is planning to request an amendment to this waiver to allow coverage of children under 8 years of age with income up to 250% of the Federal Poverty Level. State is developing a separate 1115 demonstration proposal whose target group would be disabled individuals including the mentally retarded.

Rhode Island Rite Care

The Rite Care program is a statewide initiative that seeks to increase access to, and delivery of, primary and preventive health care services for all uninsured AFDC recipients and for certain low income pregnant women and children through a fully capitated managed care delivery system.

Individuals eligible for the Rite Care program are required to enroll in prepaid health plans under contract with the State to provide comprehensive health services to enrollees for a fixed cost per enrollee per month. Eligible individuals are offered a choice of prepaid health plans in which they must enroll.

Major features of the program include:

- mandatory enrollment in a managed care plan;
- standard benefit package including enhanced services;
- capitation rate setting methodology;
- cost sharing component;
- competitive bidding process to for HMO selection;
- recipients select a managed care plan or are auto assigned to a plan;
- plans must assign a primary care physician.

South Carolina

Palmetto Senior Care Demonstration Project

PROGRAM NAME:	*ORIGINAL IMPLEMENTATION DATE:*
"Palmetto SeniorCare: 1115 Demonstration Waiver and Medicare 222 Demonstration Waiver	October 1, 1990
CONTACT:	*EXPIRATION DATE:*
Nicki Harvey (803) 253-6142	September 30, 1995, however it is Renewed annually
GEOGRAPHIC AREAS:	*NUMBER OF ENROLLEES:*
Richard and Lexington County, South Carolina	220

FFS (PCCM) OR PRE-PAID OR BOTH: Fully capitated payment integrated acute and long term care.

STATUTES UTILIZED: Authorized under PL 99-509 & 9412 and PL 100-203 & 4118

STATUTES WAIVED: The following sections of the Social Security Act were waived in the original waiver as submitted in November 1989.

1. 1902 (a) (1) - State wideness
2. 1902 (a) (1) - comparability of services
3. 1903 (m) (10) - to allow for the payment of prepaid, risk based capitation payments.
4. 1903 (f) (4) © - to allow for the courage of individuals at the higher income level (300%) of SSI who choose to participate in the waiver in lieu of institutionalization.

POPULATION CATEGORIES INCLUDED: Individuals who are age 55 and older, who live in Richland or Lexington Counties, meet the long term care criteria, and are eligible for Medicaid and Medicare or willing to privately pay a premium equal to the combined Medicaid/ Medicare capitated payment.

POPULATION CATEGORIES EXCLUDED: All individuals not meeting above criteria.

SERVICES INCLUDED: Any medical or social services in care plan including nursing home, if deemed necessary.

PCP PROVIDER TYPES: Physicians, nurses, pharmacists, therapists, home care specialist and aide. Additional services are provided through staff social workers, nutritionist, transportation teams or through medical specialty contract.

FUTURE PLANS: Palmetto SeniorCare plans to open a Fourth Day Health Center in Lexington county in early fall of 1995 to serve existing and potential clients within that county area. Total number permitted to be served remains 300 under the original approved waiver.

Palmetto SeniorCare (P.S.C.)

Palmetto Senior Care (P.C.) is one of the original six Onlok/Pace replications authorized by PL 99-509, $9412 and PL 100-203- & 4118. P.C. operates under the authority of HCFA research and demonstration waivers and requisite federal reimbursement authorized under $1115 Medicaid and $222 Medicare demonstration waivers.

P.C. serves clients in the Richland/Lexington county area who are age 55 or older, who meet nursing home level of care and who choose to participate in the waiver. Medicaid and dually Medicaid/Medicare clients are "locked in" to P.C. and receive all acute, primary, home care, long term care and other requisite health care or social services through P.C.. Services are provided either directly by P.C. staff, as in the case of primary physician care, nurse, practitioner, pharmacy, transportation etc, or through contact by P.C. with other medical specialists. The primary focus of care is through a day hospital type setting where most clients attend at least once a week. P.C. receives one capitated payment monthly from Medicaid and one from Medicare for eligible recipients dn P.C. is then responsible for all care needed by the client including inpatient hospital and nursing home care. P.C. assumes full financial risk for all care. Clients may disenroll with 30 days notice.

Tennessee

TennCare Demonstration Project

PROGRAM NAME: TennCare	*ORIGINAL IMPLEMENTATION DATE:* January 1, 1994
CONTACT: Rusty Siebert 1991 (615) 741-0213	*EXPIRATION DATE:* December 31,
GEOGRAPHIC AREAS: Statewide	*NUMBER OF ENROLLEES:* 1,183,406 (as of 10/6/95)

FFS (PCCM) OR PRE-PAID OR BOTH: Prepaid

STATUTES UTILIZED: Section 115(a); Section 1903(f); Section 1903(m)(1)(A) and (2)(A)(); Section 1903(m)(2)(A)(ii); Section 1903(m)(2)(A)(ci); 42 C.F.R. 434.20,21,26,27

STATUTES WAIVED: Section 1902(a)(10)(B); Section 1902(a)(1); Section 1902(a)(10)(A)(ii)(), (II); Section 1902(a)(34); Section 1902(a)(23); Section 1902(a)(30); Section 1902(a)(10); Section 1902(a)(13)(E); Section 1902(a)(13)(A); Section 1902(a)(54).

POPULATION CATEGORIES INCLUDED: Medicaid eligibles, uninsured and uninsurable persons.

POPULATION CATEGORIES EXCLUDED: Persons with access to health insurance.

SERVICES INCLUDED: All Title XIX services.

PCP PROVIDER TYPES: Internists, Family Practitioners, General Practitioners, OB/GYN's, and Pediatricians.

FUTURE PLANS: (1) To move to a full gatekeeper approach instead of having PPOs paying fee-for-service. (2) To incorporate a number of enhanced requirements in the TennCare /MCO contract and to monitor the compliance with these provisions closely.

Tennessee TennCare Project

On New Year's Day, 1994, Tennessee made history by withdrawing from the Medicaid program and implementing an innovative new health care reform plan called TennCare. TennCare required no new taxes and extended health coverage not only to the nearly 800,000 Tennesseans in the Medicaid population, but also to an approximately 400,000 uninsured and uninsurable persons using a system of managed care. Enrollment was open in 1994 to eligible persons in the uninsured, uninsurable, and Medicaid-eligible categories. However, as of January 1, 1995, TennCare reached 90% of its target enrollment and closed enrollment in the uninsured category. Enrollment remains open to persons who are Medicaid-eligible or who are uninsurable as determined by an insurance company which denies health insurance to the individual due to medical reasons.

Washington

Health Access Spokane Demonstration Project

PROGRAM NAME:	*ORIGINAL IMPLEMENTATION DATE:*
Health Access Spokane	
CONTACT:	*EXPIRATION DATE:*
Rochelle Salsman (360) 664-8601	March 31, 1996
GEOGRAPHIC AREAS:	*NUMBER OF ENROLLEES:*
Spokane County	2025

FFS (PCCM) OR PRE-PAID OR BOTH: Prepaid capitation

STATUTES UTILIZED: Section 1115(a)

STATUTES WAIVED: Comparability, Statewideness, and eligibility (no categorical requirements)

POPULATION CATEGORIES INCLUDED: Adults 19 to 64 years of age up to 150% of FPL.

POPULATION CATEGORIES EXCLUDED: Children, persons otherwise eligible for Medicaid or Medicare, aged over 64 years of age.

SERVICES INCLUDED: Office visits, hospital care, prescription drugs, lab & x-ray, Emergency services, ambulance, preventative care, and out of area emergency care.

PCP PROVIDER TYPES: Prepaid capitated health plans.

FUTURE PLANS: Transition eligibles to the state funded Basic Health Plan at the termination of the demonstration waiver.

Washington Health Access Spokane

The demonstration provides comprehensive health care to over 2,00 individuals in Spokane County. These individuals are uninsured with family incomes below 150% of FPL, and may be members of the working poor without employee health insurance benefits or very limited group insurance benefits. Services are provided through two managed health care plans to ensure continuity of care. This project will assure a streamlined, efficient eligibility process. The project will also seek to increase access to health care for the working poor.

The Medicaid agency is working in partnership with the Economic and Medical Field Services Division, the Office of Research and Data Analysis, the Washington Basic Health Plan, and the Spokane County business and provider communities to plan, implement and operate a successful demonstration project.

Objectives of the project are to create an innovative model which:

1. Increases access to affordable health care for the uninsured.
2. Makes health care insurance more affordable for small employers through a system of cost sharing with the state and large group purchasing arrangements.
3. Reduces administrative barriers to obtaining health care coverage by developing a system that simplifies the application process and facilitates a smooth and transparent transition between various public programs offering health care coverage.
4. Creates continuity in health care services for low income people regardless of the funding source of their health care insurance coverage.

Expected outcomes of the demonstration are:

1. An increase in the number of people in Spokane County who have health care coverage.

2. An improvement in health status of persons/enrollees in the demonstration project.

3. A decrease in the cost of purchasing publicly subsidized health care for this low-income population.

4. A decrease in administrative barriers experienced by enrollees as they change public health insurance providers.

5. An increase in public agencies' efficiency through resource sharing.

Wisconsin

Independent Care Demonstration Project

PROGRAM NAME: Independent Care*ORIGINAL IMPLEMENTATION DATE:* September 1, 1990

CONTACT: Ruth Belshaw
(608) 266-1935
Chief, Managed Care Section

EXPIRATION DATE: July 1, 1996

GEOGRAPHIC AREAS: Milwaukee *NUMBER OF ENROLLEES:* 2,148

FFS (PCCM) OR PRE-PAID OR BOTH: Prepaid

POPULATION CATEGORIES INCLUDED: SSI Disabled age 15 and older

POPULATION CATEGORIES EXCLUDED: AFDC/Healthy Start Pregnant Women

SERVICES INCLUDED: Inpatient Hospital, Outpatient Hospital, Laboratory, Rural Health Clinic, X-ray, Long Term Care, EPSDT, Family Planning, Physician, Home Health, FQHC Services, Dental, Pharmacy, Psychiatric, Chiropractic, Transportation, AODA/MH

FUTURE PLANS: Expansion for this population to two additional counties beginning January, 1997.

Wisconsin Independent Care Demonstration Project

Population: Disabled SSI recipients who are aged 15 or over and who live in Milwaukee County may voluntarily enroll in an HMO. The program began as a research and demonstration grant funded by HCFA in the summer of 1994. Enrollment will be limited to 3,000. ***Providers:*** Wisconsin contracts with one HMO, Independent Care (ICare) which is a joint venture between an HMO and a community vocational training agency. ICare's provider network continues to expand as new recipients enroll. Potential members identify the providers they have been seeing, and ICare representatives invite these providers to join their network. ***Services:*** Care coordination services are an integral part of the full array of Medicaid-covered services available to ICare members. Members have a care coordinator who helps them receive appropriate services. ***Capitation:*** The capitation rate is 95% of the FFS equivalent as determined by an actuary. For the demonstration, the state and HMO have a risk-sharing plan in the contract. ***Savings:*** We estimate saving approximately $80,000 in the first year of this program including the start-up costs. Savings are expected to increase in future years.

Wisconsin

Community Care for the Elderly (PACE) Demonstration Project

PROGRAM NAME:	*ORIGINAL IMPLEMENTATION DATE:*
Community Care for the Elderly (PACE Program)	November 1990
CONTACT:	*EXPIRATION DATE:*
Ruth Belshaw Chief, Managed Care Section (608)266-1935	1115 Waiver expires in October, 1995. Contract with State of Wisconsin expires on Dec. 31, 1995
GEOGRAPHIC AREAS:	*NUMBER OF ENROLLEES:*
Milwaukee County	262

FFS (PCCM) OR PRE-PAID OR BOTH: Prepaid

STATUTES UTILIZED: 1115(a) Medicaid waiver

STATUTES WAIVED: 1115 Medicaid waiver only

POPULATION CATEGORIES INCLUDED: Medicaid and/or individuals who are dually eligible for both Medicaid and Medicare, age 55+ who meet nursing home care level criteria.

POPULATION CATEGORIES EXCLUDED: AFDC/Healthy Start, Healthy Start Pregnant Women, SSI Disabled under age 55.

SERVICES INCLUDED: At a minimum, Adult Health Care, Home Care, Medical Care, Allied Health Services, Inpatient Care which includes Acute Care and Nursing Facility Care.

FUTURE PLANS: Expansion of PACE (Options) program. Establishing Partnership program in 1996.

Wisconsin Community Care for the Elderly (PACE) Demonstration Project

Population: These voluntary programs are for frail elderly persons who meet both the income and nursing home level-of-care eligibility criteria for Medicaid. Wisconsin's first PACE site, Community Care for the Elderly (CCE) in Milwaukee County, has been operating since 1989 and has over 200 members. The second, ElderCare in Dane County, began in January, 1995 and will serve up to 300 persons.

Providers: Both PACE sites are operated by community-based organizations.

Services: The full array of Medicaid-covered services allows these members to remain in the community.

Capitation: Both Medicaid and Medicare capitate funds for PACE programs. Wisconsin pays 95% of the FFS equivalent for the Medicaid capitation rate. During the first four years CCE and the state had a risk-sharing plan in the contract. As that plan phased out, CCE assumed full risk. The same risk sharing will apply to ElderCare.

Savings: The savings for CCE totaled $300,000 in 1994.

Glossary of CommonTerms

FFS	Fee-for-Service
AFDC	Aid to Families with Dependent Children beneficiaries
SSI	Supplemental Security Income beneficiaries
FQHC	Federally Qualified Health Centers
RHC	Rural Health Clinics
PCP	Primary Care Provider

PCCM Primary Care Case Management System -- A Freedom of Choice waiver program, under the authority of section 1915(b) of the Social Security Act (the Act) States contract directly with primary care providers who agree to be responsible for the provision and /or coordination of medical services to Medicaid beneficiaries under their care. Currently, most PCCM programs pay the primary care provider a monthly case management fee in addition to receiving fee-for-service payment for services.

HMO Health Maintenance Organization -- an entity that contracts on a prepaid, capitated risk basis to provide comprehensive health services to beneficiaries

PHP Prepaid Health Plan -- an entity that contracts on a prepaid, capitated risk basis to provide non-comprehensive health services to beneficiaries

1915(b)(1) Primary Care Case Management (PCCM) or Speciality Physician Services Arrangements provision. Under this provision, the State may restrict the provider from or through whom a recipient can obtain medical services.

1915(b)(2) Locality as Central Broker provision. Under this provision, a locality may act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among Primary Care Providers in order to provide recipients with more information about the range of health care options open to them.

1915(b)(3) Sharing of Cost Savings provision. The State may share cost savings resulting from the use of more cost effective medical care with recipients by providing them with additional services.

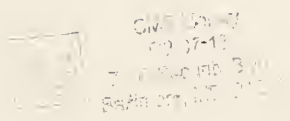
1915(b)(4) Restriction of Recipients to Specified Providers provision. Under this provision, the State may require recipients to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services.

1115(a) Research and Demonstration Clause--State utilizes specific authority within Section 1115(a) of the Social Security Act to allow the State to provide services through the vehicle of a Research and Demonstration Health Care Reform waiver program.

1902(a)(1) Statewideness. This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. Waiving 1902(a)(1) indicates that this waiver program is not available throughout the State.

1902(a)(10)(B) Comparability of Services. This section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance.

1902(a)(23) Freedom of Choice. This section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted.



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